BALANCED BUDGET ACT OF 1997

MEDICARE AND MEDICAID PROVISIONS

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SUBTITLE A--MEDICARE+CHOICE PROGRAM

Chapter 1--Medicare+Choice Program

Subchapter A--Medicare+Choice Program

Establishment of Medicare+Choice Program (Section 4001)

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- Section 1851 Eligibility, Election, and Enrollment
- Section 1852 Benefits and Beneficiary Protections
- Section 1853 Payments to Medicare+Choice Organizations
- Section 1854 Premiums
- Section 1855 Organizational and Financial Requirements for Medicare+Choice Organizations; Provider-Sponsored Organizations
- Section 1856 Establishment of Standards
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(There is no Section 1858)

- Section 1859 Definitions; Miscellaneous Provisions

"Section 1851. Eligibility, Election, and Enrollment"

Provisions

- Choices--Most Medicare beneficiaries can choose to receive benefits through the original Medicare fee-for-service program or through one of the following Medicare+Choice plans:

  + Coordinated care plans, which includes health maintenance organizations (with or without point of service options), Provider-Sponsored Organizations (PSOs) and Preferred Providers Organizations (PPOs), religious fraternal benefits plans, and other coordinated care plans that meet the Medicare+Choice standards;

  + Medical Savings Account (MSA)/High Deductible Plans (under a demonstration in which up to 390,000 beneficiaries may enroll, with no new enrollments permitted after January 1, 2003). (NOTE: Federal annuitants could not enroll in these plans unless OMB certifies that it would not increase FEHB costs. Similar rules could be applied for individuals eligible for DOD and VA health benefits. QMBs, SLMBs and other Medicaid-eligibles would not be eligible to enroll in these plans.);

+ Private fee-for-service plans.

Beneficiaries entitled to Part A and enrolled in Part B are eligible to enroll in a plan that serves the geographic area in which they reside, except beneficiaries with ESRD (although beneficiaries who develop ESRD may remain in the plan if already enrolled). Part B only enrollees are ineligible.

o Enrollment/Disenrollment Process--The Secretary would establish procedures for enrollment and disenrollment in Medicare+Choice options, including through the Medicare+Choice plan. Newly eligible enrollees who do not choose a Medicare+Choice plan are deemed to have chosen the original Medicare fee-for-service option, except that the Secretary may establish procedures under which "age-ins"enrolled in a plan with a Medicare+Choice contract are deemed to have elected that plan for their Medicare coverage. Individuals remain enrolled in the option of their choice until they choose another plan.

o Providing Information to Beneficiaries--At least 15 days before a required November coordinated election period (see below), the Secretary must mail to each beneficiary general information on Medicare and comparative information on Medicare+Choice plans available in their area. General information includes information on covered benefits, cost sharing and balance billing liability under the original fee-for-service program; election procedures; grievance and appeals rights; information on Medigap and Medicare SELECT. Comparative information includes extensive information on benefits and beneficiary liability; premiums; service areas; quality and performance; and supplemental benefits. The Secretary must make available a toll-free number for inquiries on Medicare+Choice options and an Internet site providing information on Medicare+Choice options.

o Enrollment Periods (except for MSAs)--Beneficiaries can choose a Medicare+Choice plan at initial eligibility or during one of the enrollment periods described below. From 1998 through 2001, they can enroll (if the plan is open to new enrollees) or disenroll on a monthly basis. For the first six months of 2002 (or the first six months of eligibility in a year, in the case of newly eligible beneficiaries), beneficiaries can enroll and disenroll from plans, but they could only change plans once during that period. The same process applies after 2002, except the six-month time frame becomes a three-month time frame.

+ The annual coordinated enrollment period is in November of each year, beginning in 1999 (although all plans must also be open in November of 1998). Enrollments at this time are effective the following January 1. In conjunction with the annual coordinated enrollment period, the Secretary must sponsor a "Health Information Fair" to publicize Medicare+Choice options. (During 1998, the Secretary will conduct a special information campaign for this purpose.)

+ Beginning in 2002, special election periods would be available in which beneficiary can disenroll if the plans was terminated, the beneficiary moved out of the plan's service area or the beneficiary demonstrates that the plan violated its contract or misrepresented the plan in marketing, and any other conditions specified by the Secretary.

+ Also, beginning in 2002, newly eligible beneficiaries who elect a Medicare+Choice option may disenroll into the original Medicare fee-for-service option any time during the first 12 months of their enrollment.

o MSA Enrollment Periods--Beneficiaries may elect the MSA option only at initial eligibility or during November of any year, beginning in 1998. New MSA enrollees may revoke their election if they do so before December 15 of the year in which they make the election, i.e., before their MSA coverage begins.

o Anti-Discrimination--Plans would have to accept all beneficiaries on a first-come-first-served basis, subject to capacity limits.

o Disenrollment of Individual Beneficiaries by their Plan--Plans may only disenroll beneficiaries for cause (i.e., failure to pay premiums or disruptive behavior) or plan termination in the beneficiary's geographic area. Beneficiaries terminated for cause are enrolled in the original Medicare fee-for-service program. Others may have a special election period.

o Marketing Material Approval--Medicare+Choice plans must submit marketing materials, including application forms, to the Secretary at least 45 days before distribution. The material can be distributed if not disapproved by the Secretary. The Secretary would disapprove marketing materials if they are materially inaccurate or misleading. Medicare+Choice plans must conform to fair marketing standards, including a prohibition on the plan offering cash or rebates. If a plan's marketing materials were approved for one service area, they will be deemed to be approved in all of the plan's service areas, except in regard to area-specific information.

Effective Date

o Upon enactment. Note that organizations cannot contract to enroll Medicare beneficiaries under the Medicare+Choice program until they have met standards, to be published June 1, 1998 (see Section 1856 - Establishment of Standards). In general, organizations with contracts under Section 1876 will contract under the Section 1876 standards through 1998 and under the Medicare+Choice standards beginning January 1, 1999. However, specified Medicare+Choice provisions do apply to Section 1876 contracts before January 1, 1999 (see Section 4002 - Transitional Rules for Current Medicare HMO Program).

"Section 1852 Benefits and Beneficiary Protections"

Provisions

- Basic Benefits--Except for MSA-plans, all Medicare+Choice plans are required to provide the current Medicare benefit package (excluding hospice services) and any additional health services required under the adjusted community rate (ACR) process. A Medicare+Choice plan would not have to provide hospice care. For benefits provided by MSA plans, see "Section 1859 Definitions."

- Payments to Non-Contracting Providers and Others--Except for MSA-plans, Medicare+Choice plans must provide payments to non-contracting providers or other persons so that the total payment (the plan's payment plus any cost sharing) are equal to at least the total payment that would have been paid under Medicare fee-for-service, including any balance billing amounts. Also, see description of "Balance Billing Limits" in Section 1852, as well as "Limits on Beneficiary Liability" in Section 1854.

- Supplemental Benefits--Except for MSA plans, Medicare+Choice plans could offer mandatory supplemental benefits, subject to the Secretary's approval. The Secretary must approve mandatory supplemental benefits unless she determines that offering such benefits would substantially discourage enrollment. Medicare+Choice plans could offer optional supplemental benefits. MSA plans may not provide optional supplemental benefits that cover the deductible. Private fee-for-service plans may offer supplemental benefits that include payment for some or all of the permitted balance billing amounts and additional services that the plan determines are medically necessary.

- Organization as Secondary Payer--In circumstances where secondary payer rules apply, Medicare+Choice plans could seek payment from other payers, such as insurers or employer plans, or from the Medicare+Choice enrollee if he or she has been paid by other payers.

- National Coverage Determinations--With respect to national coverage determinations made in the period between the annual announcements of Medicare+Choice capitation rates, the application of such determinations would be delayed if the determination would result in a significant change in costs to Medicare+Choice plans and the change had not been incorporated in the annual Medicare+Choice capitations rates. In the case of such determinations, the national coverage determination would apply to the first contract year beginning after that period. Prior to the application of the determination, Medicare+Choice plans would submit claims and receive payment under the original fee-for-service Medicare program.

- Beneficiary Protections--In general, Medicare+Choice plans must meet standards similar to those under current law related to disclosure, access, quality, grievances and appeals,

confidentiality, and information on advance directives.

- Antidiscrimination--Medicare+Choice plans cannot health screen enrollees or discriminate with respect to participation, payment, or indemnification against any provider acting within the scope of the provider's license or certification. This provision would not limit the Medicare+Choice plan's ability to selectively contract.

- Disclosure--The Medicare+Choice plan must provide in a clear, accurate, and standardized form certain information to each enrollee, such as the plan's service area, benefits, number, mix and distribution of providers, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, appeals and grievance procedures and quality assurance program. Upon request, enrollees must be provided comparative information, information on the plan's utilization control mechanisms, information on the number of grievances and appeals and their disposition in the aggregate and a summary of physician compensation arrangements.

- Access to Services--Medicare+Choice plans are permitted to select the providers who may furnish benefits to enrollees, as long as such benefits are available and accessible to all enrollees with reasonable promptness and assured continuity, 24 hours a day, 7 days a week. The plan must also cover services provided other than through the organization for: (1) non-emergency services needed immediately because of an unforeseen illness or injury, if it was not reasonable to obtain the services through the plan; (2) renal dialysis services for enrollees who are temporarily out of the plan's service area; and (3) maintenance or post-stabilization care after an emergency condition has been stabilized, subject to guidelines established by the Secretary.

  Medicare+Choice plans are required to pay for emergency services without regard to prior authorization or whether the provider has a contractual relationship with the plan. An emergency medical condition is defined using a "prudent layperson" standard (including conditions that may be manifested by "severe pain").

  Private fee-for-service plans must demonstrate that the plan includes a sufficient number and range of providers willing to furnish services. This requirement is presumed to have been met if the plan has established payment rates that are not less than payment rates under Medicare, and/or has contracts or agreements with a sufficient number and range of providers.

- Quality Assurance Program--Medicare+Choice plans must have an internal quality assurance program. The statute sets forth numerous requirements for internal quality assurance programs, but also provides that private fee-for-service plans and non-network MSA plans must meet only a subset of those requirements, plus two requirements specific to those plans. Plans could meet internal quality assurance requirements by receiving accreditation from a private organization approved by the Secretary. Medicare+Choice

plans (except private fee-for-service plans and non-network MSA plans that do not employ utilization review) must also undergo external quality reviews by PROs or independent review organizations. Except in the case of the review of quality complaints, the Secretary would be required to ensure that the external review activities were not duplicative of the review activities conducted as part of the accreditation process. The Secretary could waive external review requirements for organizations with good track records.

o Grievances, Coverage Determinations, Reconsiderations and Appeals--As under current law, Medicare+Choice plans must maintain meaningful procedures for hearing and resolving grievances.

Medicare+Choice plans must have a procedure for making determinations regarding whether an enrollee is entitled to receive services and the amount the individual is required to pay for such services. Determinations must be made on a timely basis. The explanation of a plan's determination must be in writing and must explain the reasons for the denial in understandable language and describe the reconsideration and appeals processes. The time period for reconsiderations would be specified by the Secretary but could not be greater than 60 days after the request by the enrollee. Reconsiderations of coverage determinations to deny coverage based on lack of medical necessity must be made by a physician with expertise in the field of medicine which relates to the condition necessitating treatment.

Plans would be required to have an expedited review process in cases where the normal time frame for making a determination or reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Either the beneficiary or the physician could request an expedited review. Requests for expedited reviews made by physicians (even those not affiliated with the organization) must be granted by the plan. Expedited determinations and reconsiderations must be made within time periods specified by the Secretary, but not later than 72 hours after the request for expedited review, or such longer period as the Secretary may permit in specified cases.

The Secretary would be required to contract with an independent, outside entity to review and resolve plan reconsiderations not favorable to the beneficiary. If the independent review is unfavorable to the beneficiary, the beneficiary would have right to the same appeal process (e.g, ALJ, judicial review) as under existing HMO procedures.

o Confidentiality and Accuracy of Enrollee Records--Medicare+Choice plans must establish procedures to safeguard the privacy of identifiable enrollee information, to maintain accurate and timely medical records, and to assure timely access of enrollees to their medical records.

- Advance Directives--Each Medicare+Choice plan must maintain written policies and procedures respecting advance directives.

- Rules Regarding Provider Participation--Medicare+Choice plans must establish procedures relating to participation of physicians in the plan such as notice of rules of participation, written notice of adverse participation decisions and an appeals process. Medicare+Choice plans must consult with participating physicians regarding medical policy, quality, and medical management procedures.

  Prohibits plans from restricting health care professionals from advising their patients about the patient's health status or treatment options. Includes a "conscience protection" clause exempting a plan from being required to provide or cover a counseling or referral service if the plan (1) objects on moral or religious grounds, and (2) informs prospective enrollees of such policy before or during enrollment, and current enrollees within 90 days after adopting a change in such policy.

  Current law requirements for physician incentive plans are maintained. Plans may not require that providers, physicians or other entities indemnify the organization against liability for civil actions.

  A provider, health professional or other entity would be treated as having a contract with a private fee-for-service plan if the provider, health professional or other entity furnished services that were covered under a private fee-for-service plan and before providing those services, the provider, professional or other entity was informed of the individual's enrollment and either was informed of the terms and conditions of payment for such services under the private fee-for-service plan or was given a reasonable opportunity to obtain information concerning the terms and conditions.

- Balance Billing Limits--Except for MSA plans, non-contracting physicians and other entities must accept as payment in full the amount that would have been paid under Medicare fee-for-service. Non-contracting providers must also accept as payment in full, the amount that would have been paid under Medicare. [Section 1866(a)(1)(O)].

  Contracting physicians, providers and other entities of private fee-for-service plans must accept as payment in full an amount not to exceed (including any deductibles, coinsurance, copayments or balance billing permitted under the plan) an amount equal to 115 percent of the plan's payment rate. Plans would have to establish procedures to carry out this requirement. If a plan does not establish and enforce such procedures, the plan would be subject to intermediate sanctions.

  Private fee-for-service plans must provide enrollees with an explanation of benefits that includes a clear statement regarding enrollee liability, including any balance billing. The plan would also have to provide that the hospital give enrollees prior notice before they

receive inpatient services and certain other services, when the amount of balance billing could be substantial. The notice must include a good faith estimate of the likely amount of balance billing based upon the presenting conditions of the enrollee.

Effective Date

- Upon enactment. Note that organizations cannot contract to enroll Medicare beneficiaries under the Medicare+Choice program until they have met standards, to be published June 1, 1998 (see Section 1856 - Establishment of Standards). In general, organizations with contracts under Section 1876 will contract under the Section 1876 standards through 1998 and under the Medicare+Choice standards beginning January 1, 1999. However, specified Medicare+Choice provisions do apply to Section 1876 contracts before January 1, 1999 (see Section 4002 - Transitional Rules for Current Medicare HMO Program).

"Section 1853 Payments to Medicare+Choice Organizations"

Provisions

- General Methodology--In general, beginning in 1998, Medicare capitation rates paid to plans will be the greater of:

  + a blend of the area-specific rate and an input-price adjusted national rate, further adjusted by budget neutrality adjustments;

  + a minimum payment amount; or

  + a minimum percentage increase.

  The 1997 capitation rates (from the 1997 AAPCC ratebook) will be the base for (1) the area-specific rates in the blend and (2) the minimum percentage increase rates. In an area where the 1997 AAPCC varies by more than 20 percent from the 1996 AAPCC, the Secretary can substitute for the 1997 rate, a rate that is more representative of the cost of enrollees in the area.

  Rates will be announced by March 1 of the year before the year to which they apply. As under prior law, 45 days before the announcement, the Secretary will provide notice of changes in the methodology and assumptions used in the previous year.

- Blended Rates

  + Area-Specific Rate--For 1998, the base for the area-specific rate would be the 1997 AAPCC rate (adjusted for 20 percent of the IME/GME carve out). Thereafter, it will be the rate for the previous year adjusted using the update

factors described below (again, with the 1997 base adjusted for the appropriate percentage of the carve-out).

+ Input-Price Adjusted Annual National Capitation Rate--The sum, for all types of Medicare services, of the product of three amounts: (1) the national standardized annual capitation rate for the year (defined as the weighted average of area-specific capitation rates); (2) the proportion of such rate for the year which is attributable to such type of services, and (3) an index that reflects (for that year and that type of service) the relative input price of such services in the area, as compared to the national average input price of such services.

+ Carve Out of IME and GME--Between 1998 and 2002, IME (indirect medical education) and GME (graduate medical education) payments will be carved out of the area-specific base rate, on the following schedule: 20 percent in 1998, 40 percent in 1999; 60 percent in 2000; 80 percent in 2001; and 100 percent in 2002 and thereafter.

+ Budget Neutrality--Blended rates will be adjusted so that total payments under Part C equal what would have been paid if payments were based on 100 percent of the area-specific rates.

+ Blend Percentage--The blended rate will transition from 90 percent area-specific/10 percent national in 1998 to 50 percent area-specific/50 percent national in 2003, as follows: 90/10 in 1998; 82/18 in 1999, 74/26 in 2000, 66/34 in 2001, 58/42 in 2002, and 50/50 in 2003 and thereafter.

o Minimum Payment--The minimum payment amount will equal $367 per month per enrollee in 1998, but not to exceed 150 percent of the 1997 AAPCC in areas outside the 50 states and the District of Columbia. The minimum payment will be adjusted each year using the update factors described below.

o Minimum Percentage Increase--For 1998, the minimum percentage increase is 102 percent of the 1997 AAPCC. Thereafter, it is 102 percent of the prior year's rate.

o Update Factors--The update factors for (1) the area-specific rates in the blend and (2) the minimum percentage increase rates will be the national average per capita Medicare growth rate, reduced by 0.8 percentage points for 1998, and 0.5 percentage points for 1999 through 2002, and 0.0 percentage points thereafter.

o Payment Area--The payment area is the county or equivalent area specified by the Secretary, except for individuals determined to have ESRD, when the area is the State or equivalent area. For contract years after 1998, States would be able to request (at least 11 months in advance) that the Secretary specify a different geographic area for payment

rates, e.g., a statewide rate, or rates based on Metropolitan Statistical Areas. Such changes would be subject to a budget neutrality requirement.

- Risk Adjustment--The Secretary is required to develop and submit to Congress by March 1, 1999, a report on a proposed method of risk adjustment of payment rates. Plans will be required to submit data for hospital stays beginning July 1, 1997 and data for other services beginning July 1, 1998. No data would have to be provided to HCFA before January 1, 1998. The Secretary is to provide for implementation of a risk adjustment methodology for payments for periods beginning on or after January 1, 2000. The same risk adjustment methodology will be used for all enrollees in Medicare+Choice plans.

- ESRD Networks--Payments for ESRD networks will be made from Medicare capitation payments. These payments will be subject to the same requirements as those under the original Medicare fee-for-service program.

- Deposits to MSAs--The difference between the Medicare capitation rate and the premium for an MSA/high deductible plan will be deposited in the MSA account designated by the enrollee. Deposits for the entire year would be made at the start of the year. If the beneficiary terminated the MSA election mid-year, the Secretary can recover amounts attributable to the remaining months.

- Payments from Trust Funds--Payments to Medicare+Choice organizations will be made from the Part A and the Part B trust funds in the same proportion as payments for the Medicare program as a whole. For payments to be made for October of 2000, 2001, and 2006, specific payment dates in October or the preceding September are specified.

- Enrollment and Disenrollment During a Hospital Stay--As under prior law, when a beneficiary's date of enrollment or disenrollment occurs during a hospital stay, the hospital's payment for the entire stay will come from the beneficiary's choice (original Medicare fee-for-service or a Medicare+Choice plan or, if applicable, a section 1876 plan) on the date of the hospital admission.

- Special Rules for Hospice Election--If a Medicare+Choice plan enrollee elects to receive hospice care, the capitation payment to the plan will be reduced to cover only the amount for additional benefits (see "Section 1854" for information on additional benefits). The hospice will receive its standard Medicare payments for hospice care. The enrollee may seek non-hospice services either through his or her Medicare+Choice plan or through the original Medicare fee-for-service plan. Services provided by the Medicare+Choice plan will be paid using the Medicare fee-for-service methodology rather than through a capitation payment.

Effective Date

- The new payment methodology is effective January 1, 1998.

"Section 1854 Premiums"

Provisions

- Submission of Proposed Premium--By May 1, all Medicare+Choice plans must submit to the Secretary information on enrollment capacity. Managed care plans must submit adjusted community rate (ACR) proposals for basic and supplemental benefits, the plan's premium for the basic and supplemental benefits, a description of cost sharing and the actuarial value of cost sharing for basic and supplemental benefits and a description of any additional benefits and the value of these benefits. MSA plans must submit the monthly premium and the monthly premium for supplemental benefits. Private fee-for-service plans must submit ACRs for basic and additional benefits, the premium for the basic and additional benefits, a description of cost sharing and the actuarial value of the cost sharing, a description of additional benefits and the actuarial value of these benefits, and the supplemental premium.

  In general, the Secretary must review ACRs, premiums, and the actuarial values mentioned above and approve or disapprove these rates, amounts, and values. However, the Secretary would not review premiums for MSAs or private fee-for-service plans.

- Terms and Conditions of Imposing Premiums--A Medicare+Choice plan could terminate an enrollee for failure to pay premiums but only under specified conditions. A Medicare+Choice organization could not offer cash or other monetary rebates as an inducement for enrollment or otherwise.

- Uniform Premiums--Premiums (defined for these purposes to include cost sharing) could not vary among plan enrollees.

- Limit on Beneficiary Liability--Except for private fee-for-service and MSA plans, the Medicare+Choice premium plus the actuarial value of cost sharing for basic and additional benefits could not exceed the actuarial value of cost sharing under Medicare fee-for-service. For private fee-for-service plans, the actuarial value of cost sharing for basic and additional benefits under the plan cannot exceed the actuarial value of cost sharing under fee-for-service Medicare. Except for MSAs and private fee-for-service plans, the premium for supplemental benefits plus the actuarial value of cost sharing could not exceed the plan's ACR for such benefits.

- Additional Benefits--Except for MSAs, if the ACR for Medicare covered benefits is less than the plan's average capitation payments, the plan would have to provide additional benefits.

- Prohibition of State Imposition of Premium Taxes--No State could impose a premium tax or similar tax on premiums of Medicare+Choice plans or the offering of such plans.

Effective Date

- Upon enactment. Note that organizations cannot contract to enroll Medicare beneficiaries under the Medicare+Choice program until they have met standards, to be published June 1, 1998 (see Section 1856 - Establishment of Standards). In general, organizations with contracts under Section 1876 will contract under the Section 1876 standards through 1998 and under the Medicare+Choice standards beginning January 1, 1999. However, specified Medicare+Choice provisions do apply to Section 1876 contracts before January 1, 1999 (see Section 4002 - Transitional Rules for Current Medicare HMO Program).

"Section 1855 Organizational and Financial Requirements for Medicare+Choice Organizations; Provider Sponsored Organizations"

Provisions

- State Licensed--A Medicare+Choice plan must be organized and licensed under State law as a risk bearing entity to offer health insurance or health benefits coverage. Special rules apply for PSOs as described below.

- Full Risk--Medicare+Choice plans must assume full financial risk for the provision of Medicare services except that plans could: (1) obtain insurance or make other arrangements for costs in excess of amounts periodically determined by the Secretary; plans could obtain insurance or make arrangements for services needing to be provided other than through the plan; (2) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its fiscal year costs exceeded 115 percent of its income for such a year; (3) make arrangements with providers or health institutions to assume all or part of the risk on a prospective basis for the provision of basic services.

- Licensure for PSOs--PSOs could seek waivers of the requirement for State licensure from the Secretary by filing an application no later than November 1, 2002. The waiver is effective for 3 years, is not applicable in any other State and is not renewable. The Secretary must approve applications for waivers within 60 days.

  The waiver application must be approved if: (1) the State failed to process the licensure application within 90 days; (2) the State's non-solvency standards or review process were not generally applicable to other entities in substantially the same business or the State required the PSOs as a condition of licensure to offer any product or plan other than a Medicare+Choice plan; or (3) for applications filed after the publication of Federal solvency standards for PSOs, the State imposed solvency standards which were not the same as Federal standards or the State's solvency standards or review process imposed

requirements that were not generally applicable to other entities in substantially the same business.

PSOs with waivers must still comply with all State consumer protection and quality standards as long as those standards are consistent with standards for Medicare+Choice plans and are generally applicable to other Medicare+Choice organizations. The Secretary could enter into agreements with States for monitoring and enforcement activities with regard to unlicensed PSOs' compliance with such consumer protection and quality standards. The monitoring and enforcement activities must be performed in the same manner as for other Medicare+Choice plans.

By December 31, 2001, the Secretary must submit a report to Congress regarding whether the waiver process for PSOs should continue.

- Certification of Provision Against Risk of Insolvency for Unlicensed PSOs--A PSO that is not State-licensed and that has a waiver from the Secretary would be required to meet Federal solvency standards. The Secretary would have to certify that PSOs meet these solvency standards within 60 days of receipt of an application from the PSO.

- Definition of PSO--PSOs are public or private entities established by or organized by health care providers or a group of affiliated providers that provide a substantial proportion of health care items and services directly through providers or affiliated groups of providers. Affiliated providers share, directly or indirectly, substantial financial risk, and have at least a majority financial interest in the PSO.

  The Secretary would define "substantial proportion." In developing the substantial proportion definition, the Secretary would consider that PSOs should provide significantly more than the majority of services directly through affiliated providers and most of the remainder through contractual providers.

  A provider would be "affiliated" if through contract, ownership or otherwise: (1) one provider, directly or indirectly, is controlled by, or is under common control of the other; (2) both providers are part of a "controlled group" of corporations per Section 1563 of the Internal Revenue Code; (3) both providers are part of an "affiliated service" under Section 414 of the IRC; or (4) each provider is a participant in a lawful combination under which providers share "substantial financial risk".

Effective Date

- Upon enactment. Note that organizations cannot contract to enroll Medicare beneficiaries under the Medicare+Choice program until they have met standards, to be published June 1, 1998 (see Section 1856 - Establishment of Standards). In general, organizations with contracts under Section 1876 will contract under the Section 1876 standards through 1998

and under the Medicare+Choice standards beginning January 1, 1999. However, specified Medicare+Choice provisions do apply to Section 1876 contracts before January 1, 1999 (see Section 4002 - Transitional Rules for Current Medicare HMO Program).

"Section 1856 Establishment of Solvency Standards"

Provisions

- Solvency Standards for PSOs--Through expedited, negotiated rulemaking, the Secretary is required to develop interim final regulations providing solvency standards for PSOs with a target date of publication by April 1, 1998. If reaching the target appeared unlikely, Secretary could terminate the negotiated rulemaking process and publish the rule.

  In developing these standards, the Secretary is required to take into account: (1) the delivery system's assets and the PSO's ability to provide services directly; (2) alternative means of protecting against insolvency; and (3) standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

- All Other Standards--By June 1, 1998, the Secretary must establish by interim final regulations all other standards for Medicare+Choice organizations consistent with Part C and based on section 1876 standards. Federal non-solvency standards will preempt any State law or regulation with respect to Medicare+Choice plans that are inconsistent with Federal standards. Specifically, State standards with regard to benefit requirements, requirements relating to inclusion or treatment by providers and coverage determinations (including related appeals and grievance processes) will be preempted.

Effective Date

- Upon enactment. Note that organizations cannot contract to enroll Medicare beneficiaries under the Medicare+Choice program until they have met standards, to be published June 1, 1998 (see Section 1856 - Establishment of Standards). In general, organizations with contracts under Section 1876 will contract under the Section 1876 standards through 1998 and under the Medicare+Choice standards beginning January 1, 1999. However, specified Medicare+Choice provisions do apply to Section 1876 contracts before January 1, 1999 (see Section 4002 - Transitional Rules for Current Medicare HMO Program).

"Section 1857 Contracts with Medicare+Choice Organizations"

Provisions

- Plans could not receive payment from the Medicare program unless they have a contract

with the Secretary. The contract period will be for one year and may be automatically renewed.

- Minimum Enrollment--Medicare+Choice plans will have to meet minimum enrollment requirements--5000 for plans in urban areas (1500 for PSOs), 1500 for plans in rural areas (500 for PSOs). These requirements could be waived in the first 3 contract years. In applying minimum enrollment requirements to MSA plans, covered lives would is substituted for individuals.

- Contract Period and Effectiveness--Contracts are effective for at least one year and are automatically renewable in the absence of notice by either party of intention to terminate. The Secretary could terminate a contract if: (1) the organization had failed to substantially carry out the contract; (2) was carrying it out in a manner substantially inconsistent with the efficient and effective administration of the Medicare+Choice program; (3) no longer substantially met Medicare+Choice conditions. The Secretary may not contract with a plan that has been terminated within the last 5 years, except in special circumstances as determined by the Secretary.

- Monitoring--The Secretary or designee would have the right to audit or otherwise evaluate the plan.

- Periodic Auditing of Financial Records--The Secretary must annually audit financial records, including data related to Medicare utilization, costs, and the computation of the ACR, of at least one-third of the Medicare+Choice plans. The GAO will monitor auditing these activities.

- Cost Sharing in Enrollment-Related Costs--Medicare+Choice plans must make payments to the Secretary for their pro rata share of estimated costs related to enrollment and dissemination of information and certain counseling and assistance programs. The Secretary is authorized to collect user fees, but such fees are limited to $200 million in fiscal year 1998, $150 million in fiscal year 1999, and $100 million in fiscal year 2000 and beyond.

- Prompt Payment--Medicare+Choice plans must provide prompt payment to non-contracting providers and to enrollees in the case of private fee-for-service plans. If the Secretary determined (after notice and an opportunity for a hearing) that the plan had failed to pay providers or enrollees promptly, the Secretary could provide for direct payment. In these cases, the Secretary would reduce Medicare+Choice payments accordingly.

- Intermediate Sanctions--The Secretary could impose intermediate sanctions if the plan: (1) failed to provide medically necessary services required under law or the contract and the failure adversely affected or had the substantial likelihood of adversely affecting the

enrollee; (2) imposed premiums in excess of the premium permitted; (3) acted to expel or refused to reenroll an individual in violation of the Medicare+Choice requirements; (4) engaged in practices that effectively denied or discouraged enrollment; (5) misrepresented or falsified information to the Secretary or to others; (6) violated rules regarding physician participation; (7) employed or contracted with individuals who were excluded from participation in Medicare; or (8) performed any other actions that would be grounds for termination and, in the case of private fee-for-service plans, did not enforce balance billing limits. The remedies could include civil money penalties, suspension of enrollment or suspension of payment.

- Procedures for Termination--The Secretary must adhere to certain due process procedures before terminating a plan unless there was imminent risk to beneficiaries.

Effective Date

- Upon enactment. Note that organizations cannot contract to enroll Medicare beneficiaries under the Medicare+Choice program until they have met standards, to be published June 1, 1998 (see Section 1856 - Establishment of Standards). In general, organizations with contracts under Section 1876 will contract under the Section 1876 standards through 1998 and under the Medicare+Choice standards beginning January 1, 1999. However, specified Medicare+Choice provisions do apply to Section 1876 contracts before January 1, 1999 (see Section 4002 - Transitional Rules for Current Medicare HMO Program).

"Section 1859 Definitions; Miscellaneous Provisions"

Provisions

- Medicare+Choice Organization--A Medicare+Choice organization is defined as a public or private entity certified as meeting the section 1856 requirements and standards.

- Medicare+Choice Private Fee-for-Service Plan--A private fee-for-service plan is defined as a plan that reimburses providers on a fee-for-service basis, does not place them at risk, does not vary payment rates based on utilization, and does not restrict provider selection among those who agree to accept the plan's payment terms and conditions.

- MSA Plan--An MSA plan is defined as a plan that pays for at least all Medicare-covered items and services after the enrollee meets the annual deductible; counts toward the deductible at least all amounts that would have been paid by Medicare and by the beneficiary as deductibles, coinsurance, or copayments; and, after the deductible is met, pays the lesser of 100 percent of specified expenses or 100 percent of amounts that would have been payable (without regard to any deductibles or coinsurance) under the original fee-for-service Medicare program. The annual deductible for 1999 cannot exceed $6,000. This maximum amount will be increased annually using the update factor for

Medicare+Choice capitation payments, rounded to the nearest $50.

- Coordinated Acute and Long-Term Care Benefits--A State would not be prevented from coordinating benefits under a Medicaid plan and a Medicare+Choice Plan in a manner that assures continuity of a full range of acute care and long-term care services to poor elderly or disabled beneficiaries.

- Religious Fraternal Benefit Society Plans--Defines the terms "Medicare+Choice religious fraternal benefit society plan" and "religious fraternal benefit society." These plans may restrict enrollment to members of the church, convention or group with which the society is affiliated (other provisions of law addressing restricted enrollment notwithstanding). Payments to such plans may be adjusted, as appropriate, to take into account the actuarial characteristics and experience of plan enrollees.

Effective Date

- Upon enactment. Note that organizations cannot contract to enroll Medicare beneficiaries under the Medicare+Choice program until they have met standards, to be published June 1, 1998 (see Section 1856 - Establishment of Standards). In general, organizations with contracts under Section 1876 will contract under the Section 1876 standards through 1998 and under the Medicare+Choice standards beginning January 1, 1999. However, specified Medicare+Choice provisions do apply to Section 1876 contracts before January 1, 1999 (see Section 4002 - Transitional Rules for Current Medicare HMO Program).

Transitional Rules for Current Medicare HMO Program (Section 4002)

Provisions

- 50:50 Rule--Repeals the 50:50 rule for contract periods beginning on or after January 1, 1999. Deletes the requirement that Medicaid beneficiaries be included in the 50:50 computation and, for contract periods after December 31, 1996, the Secretary can waive or modify the 50:50 rule if she finds that it is in the public interest.

- Transition for Section 1876 Risk Contractors--Once standards, to be published by June 1, 1998, are effective, no new section 1876 risk contract may be entered. No section 1876 contracts can be renewed for a contract year beginning on or after January 1, 1999. Part B only beneficiaries who are enrolled in a risk plan on December 31, 1998 may continue their enrollment. Effective January 1998, section 1876 risk plans will be paid using the capitation payments determined under section 1853 of the Medicare+Choice provisions. Certain Medicare+Choice requirements also apply to section 1876 risk plans: (1) provision of data on hospital and other health services (section 1853); (2) restrictions in premium taxes (section 1854); (3) the requirement to accept enrollment of new enrollees during November 1998 (section 1851); and (4) payment of their pro rata share of amounts

to fund beneficiary information and counseling activities (section 1856).

- Reasonable Cost Entities--After enactment, the Secretary may not enter into any section 1876 cost contracts, except with entities that had a Health Care Prepayment Plan (HCPP) agreement immediately prior to entering a section 1876 cost contract. No section 1876 cost contracts can be entered into or renewed after December 31, 2002. The Secretary must report by January 1, 2001, on the potential impact of eliminating the reasonable cost contracting option on beneficiaries enrolled in these plans.

  In addition, upon enactment, the Secretary may enter into or renew a Health Care Prepayment Plan (HCPP) agreement only with entities sponsored by a union or employer or entities that do not provide or arrange for inpatient hospital services. (Existing HCPP agreements with entities that do not meet the criteria for an HCPP agreement would terminate December 31, 1998. As explained above, these entities could contract as section 1876 cost contractors until December 31, 2002.)

- Enrollment Transition--An individual enrolled on December 31, 1998 in a section 1876 plan will be considered to be enrolled with that plan on January 1, 1999 under Part C if the organization has a contract under Part C on that date (unless the individual had disenrolled effective January 1, 1999).

- Advance Directives--The requirements of section 1866(f) on advance directives, which apply to section 1876 contractors, will apply to Medicare+Choice plans.

- Provider Requirement--All providers will have to accept Medicare payment as payment in full for Medicare-covered services they provide to enrollees of Medicare+Choice plans and section 1876 risk plans (and certain other plans) if the provider does not have a contract with the plan. Formerly this provision applied only to hospitals and skilled nursing facilities.

- Technical Changes Proposal--Within 6 month of enactment, the Secretary must submit a legislative proposal for technical and conforming amendments needed in the Medicare+Choice program.

- PSO Enrollment Transition Rule--Entities seeking to enter a risk contract under section 1876 on or after January 1, 1998 that otherwise meet the definition of a PSO will be required to meet the Medicare+Choice minimum enrollment requirements for PSOs (1,500, or 500 if the organization serves primarily non-urban areas) rather than the section 1876 requirements.

Effective Date

- Upon enactment unless otherwise specified.

Conforming Changes in Medigap Program (Section 4003)

Provision

- Provides that a Medicare supplementary policy cannot be sold or issued to an individual with the knowledge that the policy duplicates health benefits to which the individual is entitled under the Medicare+Choice plan or another Medigap policy, unless accompanied by a written disclosure statement.

- Generally prohibits selling a policy that covers expenses that are otherwise required to be counted toward meeting the annual deductible amount under an MSA plan to a person with an MSA or a Medicare+Choice private fee-for-service plan.

- Provides that a Medicare+Choice plan is not considered a Medicare supplementary policy.

Effective Date

- Upon enactment.

Subchapter B--Special Rules for Medicare+Choice

Medical Savings Accounts

Special Rules for Medicare+Choice Medical Savings Accounts (Section 4006)

Provisions

- Exclusion from Income--Medicare's contributions to the MSA account and interest income earned on amounts held in the MSA account are not included in the taxable income of the MSA account holder.

- Contributions--Only the Secretary can make direct contributions to the MSA account. A beneficiary can transfer funds between MSA accounts.

- Withdrawals for Medical Expenses--Withdrawals from MSA accounts for qualified medical expenses are not included in the taxable income of the MSA account holder. Qualified medical expenses do not include amounts paid for medical care for anyone other than the beneficiary.

- Withdrawals for Non-Medical Expenses--Withdrawals for non-medical expenses are included as taxable income and may be subject to a penalty as well. Beneficiaries would be subject to a penalty if MSA funds are used for non-medical expenses and a minimum

balance is not maintained.

- Treatment of MSAs at Death--Upon the death of an account holder, if the beneficiary has a surviving spouse, the spouse may continue the MSA, but no new contributions can be made. Earnings on the account balance are not included in taxable income. Withdrawals for qualified medical expenses for the spouse, spouse's dependents or a subsequent spouse are not included in taxable income. Withdrawals for non-medical expenses are taxable and subject to a 15 percent excise tax unless the withdrawal is made after the surviving spouse reaches age 65 or becomes disabled.

  If the beneficiary of the MSA account is not the account holder's spouse, the account is no longer treated as an Medicare+Choice MSA account; the value of the account on the account holder's death is included in taxable income for the taxable year in which the death occurred. If the account holder fails to name a beneficiary, the value of the account is to be included in the taxable income of the account holder's final income tax return.

Effective Date

- The provision is effective with respect to taxable years beginning on or after December 31, 1998.

SUBTITLE A--MEDICARE+CHOICE PROGRAM

Chapter 2--Demonstrations

Subchapter A--Medicare+Choice Competitive Pricing Demonstration Project

Medicare Prepaid Competitive Pricing Demonstration Project (Section 4011)

Provisions

- The Secretary will conduct the demonstration in areas recommended by the Competitive Pricing Advisory Committee (see Section 4012 below). The Secretary may not change the areas recommended by the advisory committee. Initially, the advisory committee will recommend four areas, with payment under the demonstration to begin in two areas on January 1, 1999 and in two areas on January 1, 2000. Three of these areas will be urban areas and 1 will be a rural area. The advisory committee may recommend up to 3 additional areas, not later than December 31, 2002.

- The advisory committee will also make recommendations on a range of considerations including benefit design, methods for setting the price to be paid to plans, providing and

disseminating information, and evaluation methods. No modification may be made in the project design without consulting with the advisory committee.

- The Secretary will closely monitor the impact of the project on the price and quality of, and access to, Medicare services, choice of health plans, changes in enrollment, and other relevant factors. By December 31, 2002, the Secretary will report on the progress of the demonstration on these and other matters and may include recommendations for extending the project program wide.

- The Secretary may waive any Medicare requirements necessary to conduct the demonstration. The Secretary may not conduct or continue other Medicare competitive pricing demonstrations except under section 4011. Total payments under the demonstration may not exceed total payments that would have been made in the absence of this demonstration.

Effective Date

- Upon enactment

Advisory Committees (Section 4012)

Provisions

- The Competitive Pricing Advisory Committee will include independent actuaries, individuals with expertise in competitive health plan pricing, and an employee of the Office of Personnel Management with expertise in FEHBP. The advisory committee will make recommendations concerning the areas for implementing the demonstration, benefit design, methods for setting the price to be paid to plans, providing and disseminating information, and evaluation methods. It will also study and make recommendations on the feasibility of providing financial incentives and penalties to demonstration plans linked to their compliance with quality standards. The advisory committee will continue to advise the Secretary upon implementation of the demonstration and will terminate on December 31, 2004.

- After an area is designated as a demonstration site, the Secretary will appoint an area advisory committee, with representatives of health plans, providers and Medicare beneficiaries, to advise on marketing and pricing of the plan and other salient factors. The area advisory committees will operate for the duration of the demonstration in their respective areas.

- The Competitive Pricing Advisory Committee and the area advisory committees may meet as soon as the members are appointed, section 9(c) of the Federal Advisory Committee Act notwithstanding.

Effective Date

- Upon enactment.

Subchapter B--Social Health Maintenance Organizations

Social Health Maintenance Organizations (SHMOS) (Section 4014)

Provisions

- SHMO I and SHMO II demonstrations are extended through December 31, 2000. The final report is due March 31, 2001. The limit on the number of enrollees per site is increased, from 12,000 to 36,000. The Secretary must submit a report to Congress by January 1, 1999 that addresses transitioning SHMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations.

Effective Date

- Upon enactment.

Subchapter C--Medicare Subvention Demonstration Project for Military Retirees

Medicare Subvention Project for Military Retirees (Section 4015)

Provision

- Authorizes the Secretary of DoD and the Secretary of HHS to establish a demonstration project, under which, the Secretary of HHS would reimburse the Secretary of DoD from the Medicare trust funds for Medicare health care furnished to certain Medicare-eligible military retirees or dependents. The demonstration project would be established through an agreement entered into by the Secretaries. This agreement would include several provisions, such as a description of benefits to be provided, and a requirement that any facility receiving payments under the project has sufficient resources and expertise to provide the required benefits.

Effective Date

- Upon enactment.

Subchapter D--Other Projects

Medicare Coordinated Care Demonstration Project (Section 4016)

Provisions

- Based on the results of a one-year evaluation of best practices in private sector coordinated care methods, the Secretary will conduct a demonstration to evaluate methods, such as case management and other models of coordinated care that improve the quality of care and reduce Medicare expenditures for beneficiaries with chronic illnesses enrolled in the original fee-for-service Medicare program. The demonstration will be conducted in at least 9 sites: 5 urban areas; 3 rural areas; and 1 within the District of Columbia which is operated by a nonprofit academic medical center that maintains a National Cancer Institute certified comprehensive cancer center (this site has specific funding requirements).

- The Secretary will report to Congress within 2 years of implementation (and biannually thereafter) on matters including the cost-effectiveness of the projects, the quality of services, and beneficiary and provider satisfaction. If the initial report indicates that the projects reduce expenditures or are budget neutral, and increase quality of services and provider and beneficiary satisfaction, the Secretary may expand the number of demonstration projects. In addition, if any report makes such findings, the Secretary may issue regulations to implement on a permanent basis the components of the demonstration that are beneficial to the Medicare program.

Effective Date

- Within 2 years of enactment, implementation of demonstration in at least 9 areas.

Orderly Transition of Municipal Health Service Demonstration Projects (Section 4017)

Provision

- Authorizes the Secretary to extend the Municipal Health Service Demonstration Projects (MHSP) through 2000, but only for beneficiaries who received at least one service from a demonstration project between January 1, 1996 and the date of enactment of this Act. The Secretary shall work with each demonstration site to develop a transition plan to be submitted to Congress by March 31, 1998. A site that fails to submit such a plan by this date shall be discontinued as of December 31, 1998. (The demonstration includes four sites in Baltimore, San Jose, Cincinnati, and Milwaukee.)

Effective Date

- MHSP projects already in effect are extended through 2000 if specified conditions are met.

Medicare Enrollment Demonstration Project (Section 4018)

Provision

- The Secretary will implement a 3-year demonstration to evaluate the use of a third-party contract to conduct Medicare+Choice plan enrollment and disenrollment functions. Prior to implementation, the Secretary will consult with affected parties on the design of the project; selection criteria for the third-party contractor; and establishment of performance standards. If the third-party contractor is not in substantial compliance with the performance standards, enrollment and disenrollment functions will be carried out by the Medicare+Choice plans until a new third-party contractor is appointed.

Effective Date

- Upon enactment.

Extension of Certain Medicare Community Nursing Organizations Demonstration Project (Section 4019)

Provision

- The demonstration is extended for 2 years and the deadline for the report on the demonstration is due not later than 6 months before the end of the extension.

Effective Date

- Upon enactment.

SUBTITLE A--MEDICARE+CHOICE PROGRAM

Chapter 3--Commissions

National Bipartisan Commission on the Future of Medicare (Section 4021)

Provision

- Establishes a commission to conduct a study on long-term reform and the financing challenges facing the Medicare program. The Commission will be composed of 17 members: 4 appointed by the President; 6 each appointed by the Senate Majority Leader

and the Speaker of the House (no more than 4 of whom may be from the same party); and an additional member who will serve as Chairman who will be appointed jointly by the President, the Majority Leader and the Speaker of the House. A report on the commission's findings and recommendations must be submitted to the President and the Congress.

Effective Date

- Members must be appointed by December 1, 1997. The report is due by March 1, 1999.

Medicare Payment Advisory Commission (Section 4022)

Provision

- Establishes a Medicare Payment Advisory Commission to review and make recommendations to Congress on Medicare payment policies.

- The Commission must submit a report to Congress by March 1 of each year on Medicare payment policies and its recommendations. The Commission must also provide a report to Congress on June 1 of each year on issues affecting the Medicare program including changes in health care delivery and changes in the market for health care services.

- The Commission will be comprised of 15 members appointed by the Comptroller General. ProPAC and PPRC will be abolished.

Effective Date

- Members must be appointed by September 30, 1997. The first report is due by March 1, 1998.

SUBTITLE A--MEDICARE+CHOICE PROGRAM

Chapter 4--Medigap Protections

Medigap Protections (Section 4031)

Provision

- Guarantee Issuance--If an individual described below seeks to enroll in a Medigap policy within 63 days of the events described below, the issuer may not (1) deny or condition the issuance of a Medigap policy that is offered or available, (2) discriminate in the pricing of such a policy because of health status, claims experience, receipt of health care, or

medical condition, and (3) impose a preexisting condition exclusion.

- Guarantees issuance of Medigap plans "A", "B", "C", or "F" for:

  + Individuals enrolled under an employee welfare benefit plan that provides benefits supplementing Medicare if the plan terminates or ceases to provide all such benefits.

  + Persons enrolled with a Medicare+Choice organization who discontinue under circumstances permitting disenrollment other than during an annual election period. (These include: (1) the termination of the entity's certification, (2) the individual moves outside of the entity's service area; or (3) the individual elects termination due to cause.)

  + Persons enrolled with a risk or cost contract HMO, a similar organization operating under a demonstration project authority, an HCPP or a Medicare SELECT policy, if enrollment ceases under the same circumstances that permit discontinuance of a Medicare+Choice election. (In the case of a SELECT policy, there must also be no applicable provision in State law for continuation of such coverage.)

  + Individuals enrolled under a Medigap policy if enrollment ceases because of the bankruptcy or insolvency of the issuer, or because of other involuntary termination of coverage (and there is no provision under applicable state law for the continuation of such coverage), or the issuer violated or misrepresented a provision of the policy,

- Guaranteed issuance of Medigap plans "A", "B", "C", "F" <u>or</u> the Medicare supplemental policy that the individual was most recently previously enrolled in, if the individual: (1) was enrolled under a Medigap policy; (2) subsequently terminates such enrollment and enrolls with a Medicare+Choice organization, a risk or cost contract HMO, a similar organization operating under a demonstration project authority or a Medicare SELECT policy; and (3) terminates the Medicare+Choice enrollment within 12 months, but only if the individual was never previously enrolled with a Medicare+Choice entity.

- Guarantees issuance of <u>any</u> Medigap plan to an individual who upon first becoming eligible for Medicare at age 65, enrolled in a Medicare+Choice plan, and disenrolled from such plan within 12 months of the effective date of such enrollment.

Limitation on Preexisting Condition Exclusion:

- Limits the application of a preexisting condition exclusion during the initial 6-month open enrollment period for aged beneficiaries. Such an exclusion can not be imposed on

an individual who, on the date of application, had a continuous period of at least 6 months of health insurance coverage defined as "creditable coverage" under the Health Insurance Portability and Accountability Act (HIPAA). If the individual has less than 6 months coverage, the policy reduces the period of any preexisting exclusion by the aggregate of periods of "creditable coverage" applicable to the individual as of the enrollment date. The rules used to determine the reduction are based on rules used under HIPAA.

Technical Amendment

- Clarifies that certain disclosure requirements apply only to long term care insurance policies that do not coordinate with Medicare and Medicaid.

Effective Dates

- Guaranteed issue effective July 1, 1998.

- Limit on preexisting exclusion applies to policies issued on or after July 1, 1998.

- In general, a State is not deemed out of compliance due solely to failure to make changes before 1 year after the date the NAIC or Secretary makes changes to the NAIC model regulation. A longer time may be permitted if a state requires new legislation. The NAIC has 9 months to modify its model regulation to conform to the new requirements. If the NAIC does not make the changes within this time, the Secretary must make the appropriate modification in the regulations.

- Long term care policy disclosure provision effective as if included in HIPAA.

Addition of High Deductible Medigap Policies (Section 4032)

Provision

- Creates two additional Medigap standard policies with benefit packages the same as Plan F or Plan J, except that the policies would have a high deductible feature. The high deductible amount is $1,500 in 1998 and 1999, increased by the CPI in subsequent years. The beneficiary is responsible for payment of expenses up to this amount; the policy pays 100% of covered out-of-pocket expenses once the deductible has been met.

Effective Date

- Upon enactment. A delay is permitted where State legislation is required.

SUBTITLE A--MEDICARE+CHOICE PROGRAM

Chapter 5--Tax Treatment of Hospitals Participating in Provider-Sponsored Organizations

Tax Treatment of Hospital which Participate in Provider Sponsored-Organizations (Section 4041)

Provision

- An organization will not lose its tax exempt status because a hospital that it owns participates in a provider-sponsored organization, whether or not that provider-sponsored organization is tax exempt.

Effective Date

- Upon enactment.

SUBTITLE B--PREVENTION INITIATIVES

Screening Mammography (Section 4101)

Provision

- Provides coverage for annual screening mammograms for all women age 40 and over, and waives the Part B deductible for screening mammography.

Effective Date

- January 1, 1998.

Screening Pap Smear and Pelvic Exams (Section 4102)

Provision

- Provides coverage every 3 years for a screening pap smear and pelvic exam (including a clinical breast exam), or annual coverage for women (1) at high risk for cervical or vaginal cancer, or (2) of childbearing age who have had a pap smear during the preceding 3 years indicating the presence of cervical or vaginal cancer or other abnormality. Waives the Part B deductible for screening pap smears and pelvic exams. Pelvic exams will be paid under the physician fee schedule.

Effective Date

- January 1, 1998.

Prostate Cancer Screening Tests (Section 4103)

Provision

- Provides coverage for annual prostate cancer screening for men over age 50. Covered procedures include: (1) digital rectal exam, (2) prostate-specific antigen (PSA) blood test, and (3) after 2002, other procedures the Secretary finds appropriate. Payment for PSA blood test will be made under the clinical laboratory fee schedule, and other services will be paid under the physician fee schedule.

Effective Date

- January 1, 2000.

Coverage of Colorectal Screening (Section 4104)

Provisions

- Provides coverage for colorectal cancer screening procedures including: (1) fecal-occult blood tests for persons age 50 and over, (2) flexible sigmoidoscopy for persons age 50 and over, (3) colonoscopy for persons at high risk for colorectal cancer, and (4) other procedures (including screening barium enema) as the Secretary determines appropriate. By 90 days after enactment, requires the Secretary to publish a notice regarding a determination of coverage of screening barium enema.

- Sets frequency limits for each covered procedure, except the Secretary sets frequency limits for procedures covered in accordance with the Secretary's determination.

- Payment for each covered procedure is to be based on rates paid for the same procedure when done for diagnostic purposes, except the Secretary sets payment limits for procedures covered as a result of the Secretary's determination. Fecal occult blood tests will be paid under the clinical laboratory fee schedule, and other procedures will be paid under the physician fee schedule.

- For flexible sigmoidoscopies and colonoscopies performed in hospital outpatient departments (OPDs) or ambulatory surgical centers (ASCs), beginning January 1, 1999, payment is limited to the lower of the amount that would be paid if performed in an ASC or the amount that would be paid if performed in an OPD. Coinsurance for these procedures is established at 25 percent of the Medicare payment amount.

- Sets a special payment rule for flexible sigmoidoscopies and colonoscopies where such

procedures result in a biopsy or removal of a lesion.

Effective Date

- Determination of coverage for barium enemas is to be made by 90 days after enactment. Rules regarding payment for flexible sigmoidoscopies and colonoscopies in hospital outpatient departments and ambulatory surgical centers are effective January 1, 1999. Other provisions are effective January 1, 1998.

Diabetes Self-Management Benefits (Section 4105)

Provisions

- Provides coverage for diabetes outpatient self-management training to include services furnished in non-hospital-based programs (already covered in hospital-based programs). Services may be provided by physicians or other entities designated by the Secretary if they also provide other services paid by Medicare and meet quality standards established by the Secretary. A physician managing the patient's condition must certify that the services are needed under a comprehensive plan of care. Services will be paid under the physician fee schedule in amounts set by the Secretary in consultation with appropriate organizations.

- Provides coverage for blood glucose monitors and testing strips for all diabetics (already covered for insulin-dependent diabetics). Payment for testing strips used with blood glucose monitors will be reduced by 10 percent.

- Requires the Secretary to establish outcome measures for evaluating improvements in the health status of Medicare beneficiaries with diabetes, and to periodically submit recommendations to Congress on modifications to coverage of services for diabetics.

Effective Date

- Reduction in payment for testing strips is effective January 1, 1998. Other provisions are effective July 1, 1998.

Standardization of Medicare Coverage of Bone Mass Measurements (Section 4106)

Provision

- Provides coverage for procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results, at frequencies determined by the Secretary. Persons qualifying for these procedures include estrogen-deficient women at risk for osteoporosis, and persons: (1) with vertebral abnormalities,

(2) receiving long-term glucocorticoid steroid therapy, (3) with primary hyperparathyroidism, and (4) being monitored to assess the response to, or efficacy of, an approved osteoporosis drug. Services will be paid under the physician fee schedule.

Effective Date

- July 1, 1998.

Vaccines Outreach Expansion (Section 4107)

Provision

- Extends the Influenza and Pneumococcal Vaccination Campaign conducted by HCFA in conjunction with CDC and the National Coalition for Adult Immunization through fiscal year 2002. Authorizes $8 million for each fiscal year from 1998 through 2002 (60 percent payable from the Part A Trust Fund and 40 percent from the Part B Trust Fund).

Effective Date

- Covers activities from October 1, 1997 through September 30, 2002.

Study on Preventive and Enhanced Benefits (Section 4108)

Provision

- Requires the Secretary to request the National Academy of Sciences (in conjunction with the U.S. Preventive Services Task Force, as appropriate) to analyze the expansion or modification of preventive or other services covered by Medicare, considering both short and long term costs and benefits. The Secretary is to submit a report to Congress within 2 years of enactment on the findings of the analysis including, but not limited to, specific findings about coverage for (1) nutrition therapy, including enteral and parental nutrition and services provided by registered dieticians, (2) skin cancer screening, (3) medically necessary dental care, (4) routine patient care costs for beneficiaries enrolled in approved clinical trials, and (5) elimination of the time limit for coverage of immunosuppressive drugs for transplant patients. Funding for the study is to come from funds appropriated to DHHS for fiscal years 1998 and 1999, as the Secretary determines appropriate.

Effective Date

- Report to be submitted to Congress within 2 years of enactment.

SUBTITLE C--RURAL INITIATIVES

Medicare Rural Hospital Flexibility Program (Section 4201)

Provision

- Creates a new limited service hospital program, to be known as the Medicare Rural Hospital Flexibility Program. The State application to establish a Medicare Rural Hospital Flexibility Program must contain assurances concerning the designation of critical access hospitals and the development of at least one rural health network. CAHs must be located more than a 35 mile drive from another hospital, have 24 hour emergency care, have no more than 15 acute inpatient beds with a 96 hour length of stay limitation (with exceptions), and may have swing beds. Grandfather all current Rural Primary Care Hospitals (RPCH) into the new program and terminates the Essential Access Community Hospital (EACH) designation, while grandfathering existing EACHs. Montana Medical Assistance Facilities (MAFs) are grandfathered as CAHs after a one year transition period (which may be extended.) The bill authorizes $25 million for each of the fiscal years 1998 - 2002 for grants to States for planning, network development and CAH designation activities. A report is due by June 1, 1998 on alternatives to the 96 hour limitation for certain diagnoses.

Effective Date

- Services furnished on or after October 1, 1997.

Prohibiting Denial of Request by Rural Referral Centers for Reclassification on Basis of Comparability of Wages (Section 4202)

Provision

- Permanently grandfathers RRC status for any hospitals designated in 1991. Prohibits the Medicare Geographic Classification Review Board (MGCRB) from rejecting an RRC's request for reclassification on the basis of any comparison between its average hourly wage and the average hourly wage of hospitals in the area in which the RRC is located.

Effective Date

- Upon enactment.

Hospital Geographic Reclassification Permitted for Purposes of Disproportionate Share Adjustments (Section 4203)

Provision

- Allows rural hospitals to seek reclassification for the purpose of receiving higher DSH payments.

Enactment Date

- Effective upon enactment for a period of 30 months.

Medicare-Dependent, Small Rural Hospital Payment Extension (Section 4204)

Provision

- Designation for Medicare-dependent small rural hospitals expired on October 1,1994. This provision reinstates and extends the classification, and updates the target amount for inpatient costs. The provision would also permit hospitals to decline geographic reclassification for the purposes of qualifying for this designation.

Effective Date

- Applies to discharges occurring on or after October 1, 1997, and before October 1, 2001.

Rural Health Clinic Services (Section 4205)

Provisions

- Per-Visit Payment Limits for Provider-Based Rural Health Clinics--The provision extends the current per visit payment limits applicable to independent rural health clinics to provided-based clinics (other than clinics based in small rural hospitals with less than 50 beds).

- Assurance of Quality Services--The provision requires RHCs to have a quality assurance and performance program as specified by the Secretary.

- Waiver of Staffing Requirements Limited to Clinics in Program--The provision limits the current authority for the Secretary to waive the requirement that a clinic have a mid-level professional available at least 50 percent of the time. The waiver will be applicable only to clinics already providing services under Medicare, and not to entities initially seeking Medicare certification.

- Refinement of Shortage Area Requirements--The provision refines the requirements concerning the area in which an RHC is located. RHCs must be in shortage areas (HPSAs or MUAs) that have been reviewed by HRSA within the last three years. The Secretary has to find that there are insufficient numbers of needed health care practitioners in the clinic's area (not just primary care physicians). Clinics that no longer meet the shortage

area requirements will be permitted to retain their designation only if the Secretary determines that they are essential to the delivery of primary care services that would otherwise be unavailable in the area.

- Direct Payment to PAs in Decertified RHCs--The Secretary shall allow physician assistants to receive direct Medicare payments for their services if they were previously the owner of a rural health clinic that lost its RHC designation. Direct payment will be allowed for services provided before January 1, 2003.

Effective Date

- Effective upon enactment for current RHCs.

Medicare Reimbursement for Telehealth Services (Section 4206)

Provision

- Requires the Secretary to make Part B payments for professional consultation via telecommunications systems with a health care provider furnishing a service for which Medicare payment would be made for a beneficiary residing in a rural county that was designated as a health professional shortage area. In determining the amount of payments for telehealth services, the payments would be subject to Medicare coinsurance and deductible requirements, and balanced billing limits would apply to services furnished by non-participating physicians. Beneficiaries could not be billed for any telephone line charges or any facility fees. In addition, payment for telehealth services would be increased annually by the update factor for physicians' services under the fee schedule.

Effective Date

- Payments required by January 1, 1999.

Informatics, Telemedicine, and Education Demonstration Project (Section 4207)

Provision

- The Secretary must conduct a four year telemedicine demonstration project for beneficiaries with diabetes who reside in medically underserved rural and inner-city areas. The demonstration has several goals including increasing access and compliance for chronic disease care and developing a model for cost-effective delivery in both managed care and fee-for-service.

- The telemedicine provider must be a "telemedicine network" defined as a consortium of at least one tertiary care hospital, at least one medical school, no more than 4 facilities

and at least one regional telecommunications provider.

- Sets payments for services at 50% of reasonable costs. Costs include acquisition of equipment, curriculum development and training, telecommunication costs, and provider costs. There is a cap on payments of $30 million for the project.

Effective Date

- Effective 9 months after enactment.

SUBTITLE D--ANTI-FRAUD AND ABUSE PROVISIONS AND IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

Chapter 1--Revisions to Sanctions for Fraud and Abuse

Permanent Exclusion for Those Convicted of 3 Health Care Related Crimes (Section 4301)

Provision

- Excludes from Medicare or any State health care program for at least 10 years, an individual who has been convicted on one previous occasion of one or more health related crimes for which a mandatory exclusion could be imposed, including Medicare and State health care program-related crimes, patient abuse, or felonies related to health care fraud or controlled substances.

- Permanently excludes an individual who has been convicted on two or more previous occasions of such crimes.

Effective Date

- Upon enactment.

Authority to Refuse to Enter into Medicare Agreements with Individuals or Entities Convicted of Felons (Section 4302)

Provision

- Authorizes the Secretary to refuse to enter into, renew an agreement or terminate an agreement with a provider if the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of the program or program beneficiaries.

Effective Date

- Upon enactment.

Exclusion of Entity Controlled by Family Member of a Sanctioned Individual (Section 4303)

Provision

- Authorizes the Secretary to exclude from Medicare or any State health care program, those entities where a person transfers ownership or control to an immediate family member or member of the household, in anticipation of, or following, a conviction, assessment, or exclusion.

Effective Date

- 45 days after enactment.

Imposition of Civil Monetary Penalties (Section 4304)

Provision

- Provides that a CMP of up to $10,000 could be levied when a person arranges or contracts with an individual or entity for the provision of items or services when it knows or should know that the individual or entity has been excluded from a Federal health care program. The individual or entity would also be subject to an assessment of up to 3 times the amount claimed and to exclusion from Federal health care programs.

- A CMP of up to $50,000 plus up to 3 times the amount of remuneration offered, paid, solicited or received could be levied for each violation of the anti-kickback provisions of title XI of the Social Security Act.

Effective Date

- For excluded persons, effective for contracts and arrangements entered into after the date of enactment. The kickback provision applies to acts committed after the date of enactment.

SUBTITLE D--ANTI-FRAUD AND ABUSE PROVISIONS AND IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

Chapter 2--Improvements in Protecting Program Integrity

Anti-Fraud Message in Medicare Handbook and Required Information on EOMBs (Section 4311)

Provision

- The Medicare Handbook must contain (1) a statement indicating that errors occur and Medicare fraud, waste and abuse is a significant problem and encouraging beneficiaries to review any EOMB or statement for accuracy and to report any errors or questionable charges; (2) a description of a beneficiary's right to request an itemized statement from their provider for Medicare items and services; (3) a description of the beneficiary incentive program established under HIPAA; and (4) the HHS IG toll-free hotline number which receives complaints and information about waste, fraud and abuse.

- EOMBs are made mandatory by statute. The EOMBs must contain (1) a list of items or services which have been provided and the amount of payment for each item or service; (2) notice of the individual's right to request an itemized statement.

- Individuals can request written requests to any physician, provider, or supplier for itemized statements for Medicare-covered items or services. The statement must be furnished within 30 days and failure to supply such a notice may result in the imposition of a CMP. Itemized statements may be submitted to the Secretary for review. The Secretary will determine the accuracy of the statement and recover erroneous payments. A comparable provision of HIPAA is repealed.

Effective Dates

- January 1, 1998, as it effects changes in the handbook.

- January 1, 1999 for itemized statement provisions.

- Upon enactment for EOMB and repeal of HIPAA provision.

Disclosure of Information and Surety Bonds (Section 4312)

Provision

- DME suppliers, HHAs, CORFs and rehabilitation agencies would be required to provide a surety bond of at least $50,000.

- DME suppliers would also be required to identify each person with an ownership or controlling interest in the supplier or any subcontractor in which the supplier has a direct or indirect ownership interest of 5% or more.

- The Secretary may waive the law if the DME supplier, HHA, CORF, or rehabilitation agency provides a comparable bond under State law.

- The Secretary may elect to impose disclosure of information and surety bond requirements on Part A providers, suppliers, or other persons (other than physicians or other practitioners).

Effective Date

- For DME suppliers and HHAs, effective for items and services furnished on or after January 1, 1998.

- For other provisions, may be applied for items and services furnished on or after January 1, 1998.

Certain Identification Numbers (Section 4313)

Provision

- Medicare providers, with certain exceptions, would be required to report their EINs and SSNs of each disclosing entity, each person with an ownership interest and subcontractors in which the entity has a direct or indirect ownership interest of 5% or more.

- HHS would pay SSA and Treasury to verify the SSNs and EINs.

- The Secretary must report to Congress how SSNs would remain confidential before these provisions can be implemented.

Effective Date

- Effective 90 days after the Secretary submits the report to Congress on SSN confidentiality

Advisory Opinions Regarding Certain Physician Self-Referral Provisions (Section 4314)

Provision

- The Secretary must issue binding advisory opinions as to whether a physician referral for certain designated health services (other than clinical lab services) is prohibited by law.

- Requires the Secretary to base regulations on the current OIG advisory opinion regulation.

Effective Date

- Applies to requests made 90 days after date of enactment and before August 20, 2000.

Replacement of Reasonable Charge Methodology by Fee Schedules (Section 4315)

Provision

- Authorizes the Secretary to implement a statewide or other areawide fee schedule for specified items and services currently paid on a "reasonable charge" basis including: (1) medical supplies, (2) home dialysis supplies and equipment, (3) therapeutic shoes, (4) parenteral and enteral nutrients, equipment, and supplies, (5) electromyogram devices, (6) salivation devices, (7) blood products, and (8) transfusion medicine.

- Amounts paid for these services would be 80 percent of the lesser of the actual charge or the fee schedule amount. For the first year of each fee schedule, total payments must be approximately equal to what would have been paid had the fee schedule not been implemented. The fee schedules will be updated annually, based on the increase in the consumer price index for urban consumers, except no update will occur before 2003.

Effective Date

- Each fee schedule established under this section would be effective on a date specified by the Secretary.

Application of Inherent Reasonableness to All Part B Services Other Than Physicians' Services (Section 4316)

Provision

- The Secretary will describe in regulations the factors to be used in a determination that Medicare payments are grossly excessive or grossly deficient and therefore not inherently reasonable and provide for the factors to be considered in determining an appropriate amount. The factors provided by the Secretary could not increase or decrease payment amounts by more than 15 percent from the preceding year for a particular item or service. This section also clarifies existing authority, which may be used to effect changes of greater than 15 percent more or less than the prior year's payment amount. These authorities can be used for all Part B items and services except those paid under the physician fee schedule.

Effective Date

- Upon enactment.

Requirement to Furnish Diagnostic Information (Section 4317)

Provision

- Requires non-physician practitioners to provide diagnostic codes for items and services furnished by the practitioner (already required for physicians). Requires physicians and non-physician practitioners to provide diagnostic or other medical information when ordering certain items or services furnished by another entity if such information is required by the Secretary (or the Secretary's fiscal agent) in order for payment to be made to the entity furnishing the item or service. This requirement applies to orders for clinical laboratory tests and other diagnostic procedures, durable medical equipment, braces and prosthetic devices.

Effective Date

- January 1, 1998.

Report by GAO on Operation of Fraud and Abuse Control Program (Section 4318)

Provision

- Requires the GAO to report on the operation of the Medicare fraud and abuse control program no later than June 1, 1998.

Effective Date

- Upon enactment.

Competitive Bidding Demonstration Projects (Section 4319)

Provisions

- The Secretary will implement up to 5 demonstration projects of competitive bidding for Part B items and services, except physician services. Each demonstration project will include the groups of items and services specified by the Secretary and may be conducted in up to 3 competitive acquisition areas for a 3-year period. At least one project will include oxygen and oxygen equipment. All entities must meet quality standards specified by the Secretary. The Secretary may limit the number of contractors to that needed to meet projected demand for items and services covered under the contracts. Items and services not furnished by a contracting entity would not be covered, except in cases of urgent need or other circumstances specified by the Secretary. All demonstrations terminate December 31, 2002.

- The Secretary will report annually on the demonstration and will submit a final report by June 30, 2003 to the House Ways and Means, House Commerce, and Senate Finance Committees on payments, access, diversity of product selection, and quality under the demonstration. If the Secretary determines from these evaluations that the demonstration results in savings and does not reduce access, diversity of project selection or quality, the Secretary may expand the project to additional areas. Competitive acquisition areas will be, or be within, metropolitan statistical areas. The GAO will also study the effectiveness of the demonstration.

Effective Date

- Upon enactment.

Prohibiting Unnecessary and Wasteful Medicare Payments for Certain Items (Sec 4320)

Provision

- Medicare payments are prohibited for entertainment, gifts or donations, personal use of motor vehicles, costs or fines and penalties resulting from violations of Federal, State or local laws, and for education expenses for spouses, dependents, employees or contractors.

Effective Date

- Upon enactment.

Non-discrimination in Post-Hospital Referral to Home Health Agencies and Other Entities (Section 4321)

Provision

- Hospital discharge planning evaluations must include the availability of home health services in the area, may not limit qualified providers of home health services, and must disclose financial relationships with home health service entities.

- Hospitals with a financial relationship with an HHA would be required to report to the Secretary (1) the nature of the financial interest; (2) the number of individuals discharged from the hospital requiring home health services; and (3) the percentage of those individuals receiving services from the HHA. This information must be made available to the public.

Effective Date

- Discharge planning evaluation changes apply to discharges occurring 90 days after

enactment.

- The financial interest and referral pattern provisions would become effective upon the Secretary's issuance of regulations, which is to occur no later than one year after enactment.

SUBTITLE D--ANTI-FRAUD AND ABUSE PROVISIONS AND IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

Chapter 3--Clarifications and Technical Changes

Other Fraud and Abuse Related Provisions (Section 4331)

Provisions

- Mandatory and permissive exclusions would apply to any Federal health care program providing benefits, whether directly or otherwise, which is funded in whole or in part by the United States Government except for the Federal Employees Health Benefits Program.

- A CMP of up to $25,000 could be levied on a health plan that fails to report information to the Adverse Action Data Bank. The Secretary would also publicize those government agencies which fail to report information on adverse actions.

Effective Date

- Upon enactment.

SUBTITLE E--PROVISIONS RELATING TO PART A ONLY

Chapter 1--Payment of PPS Hospitals

PPS Hospital Payment Update (Section 4401)

Provision

- Establishes a 0% PPS hospital update for FY 1998; the increase in the market basket index (MB) minus 1.9 percentage points for FY 1999; MB minus 1.8 percentage points for FY 2000, and MB minus 1.1 percentage points for FY 2001 and FY 2002. For FY 2003 and subsequent fiscal years, provides the full market basket increase for all hospitals in all areas.

- Allows certain non-teaching, non-DSH hospitals and non-Medicare dependent, small rural hospital to receive higher updates than other PPS hospitals: a 0.5 percentage point increase for their PPS update in FY 1998 and a 0.3 higher percentage point increase in FY 1999 (MB minus 1.6). These updates do not affect payments to these hospitals after FY 1999 (the additional updates do not affect the hospitals' baselines). To qualify for this additional update payment, the hospital must be in a State where, in the aggregate, FY 95 margins for these types of hospitals were negative, and the hospital itself must have a negative margin in the year preceding that to which the special update applies.

Effective Date

- Effective for discharges occurring on or after October 1, 1997.

Maintaining Savings from Temporary Reduction in Capital Payments for PPS Hospitals (Section 4402)

Provision

- Rebases capital payments by the budget neutrality factor that was in place as of September 30, 1995 (15.7%) and, for discharges occurring on or after October 1, 1997 through September 30, 2002, makes an additional 2.1% reduction in capital payments.

Effective Date

- Effective for discharges occurring on or after October 1, 1997.

Disproportionate Share (Section 4403)

Provision

- DSH payment amounts otherwise payable will be reduced by 1% in FY 1998, 2% in FY 1999, 3% in FY 2000, 4% in FY 2001, 5% in FY 2002 and 0% thereafter.

- The Secretary must submit a report to the House Ways and Means Committee and the Senate Finance Committee, within one year of enactment, with recommendations for a new formula for determining DSH payments for hospitals.

Effective Date

- Effective for discharges occurring on or after October 1, 1997.

Medicare Capital Asset Sales Price Equal to Book Value (Section 4404)

Provision

- Establishes the sales price of an asset to be its net book value. The provision applies to all providers of services.

Effective Date

- December 1, 1997.

Elimination of IME and DSH Payments Attributable to Outlier Payments (Section 4405)

Provision

- Applies IME and DSH adjustments only to the base PPS payment and not to outlier payments. Adjusts thresholds for qualifying for outlier payments to include IME and DSH costs.

Effective Date

- Effective for discharges occurring on or after October 1, 1997.

Increase Base Payment Rate to Puerto Rico Hospitals (Section 4406)

Provision

- Increases the portion of the Puerto Rico PPS hospital rate attributed to the national rate to 50 percent (up from 25 percent). The resulting payment is a 50/50 blend of the national rate and the Puerto Rico rate.

Effective Date

- Effective for discharges occurring on or after October 1, 1997.

Certain Hospital Discharges to Post Acute Care (Section 4407)

Provisions

- Redefines the movement of patients from PPS facilities to post acute care providers (skilled nursing facilities, PPS-exempt hospitals, and home health) as "transfers" as opposed to "discharges" for 10 DRGs, to be specified in regulation.

- The payment for these post-acute transfers cannot exceed the sum of 50 percent of the regular transfer payment and 50 percent of the regular DRG payment.

- In order for the "transfer" to apply to home health, the home health care must be for the same condition for which a person had an inpatient stay and be delivered within an appropriate time period, as defined by the Secretary.

- Permits the Secretary to increase the number of DRGs and post acute settings beginning with FY 2001.

Effective Date

- Effective for transfers of specified DRGs occurring on or after October 1, 1998.

Reclassification of Certain Counties as Large Urban Areas under the Medicare Program (Section 4408)

Provision

- The Secretary may include Stanly County, NC in the Charlotte-Gastonia-Rock Hill, North Carolina MSA for purposes of PPS hospital payments.

Effective Date

- Beginning with fiscal year 1998.

Geographic Reclassification for Certain Disproportionately Large Hospitals (**Section 4409)**

Provision

- Directs the Secretary to establish guidelines whereby a hospital can be reclassified if its wages are 108 percent of the average wage of all other hospitals in its wage area, its wages account for 40 percent of hospital wages paid in the area, and it has been reclassified every year from FY 1992-1997.

Effective Date

- Beginning with fiscal year 1998.

Floor on Area Wage Index (Section 4410)

Provisions

- Ensures that non-rural hospitals have an area wage index at least as high as the rural wage index in that State.

- o Excludes SNF overhead wages for certain hospitals when calculating the average wage for purposes of wage index reclassification.

Effective Date

- o Effective beginning in fiscal year 1998.

SUBTITLE E--PROVISIONS RELATING TO PART A ONLY

Chapter 2--Payment of PPS-Exempt Hospitals

Subchapter A--General Payment Provisions

Payment Update (Section 4411)

Provisions

- o Sets the FY 1998 update at 0%.

- o For FYs 1999-2002, the update factor would depend on the differences between a hospital's target amount (base year average cost per discharge updated for inflation) and its costs.

    - + For hospitals with costs that equal or exceed their target amounts by 10% or more, the update is the market basket (MB);

    - + For hospitals that exceed their target by less than 10%, the update factor would be equal to the MB-.25% for each percentage point by which costs are less than 10% over the target (but in no case less than 0);

    - + For hospitals that are at or below their target but not below two-thirds of the target amount, the update is MB-2.5% (but in no case less than 0); and

    - + For hospitals that do not exceed two-thirds of their target amount, the update factor is 0%.

    - + For calculating exception payments, the update factor for FYs 1998-2002 is equal to the market basket percentage for that year.

Effective Date

- o For cost reporting periods beginning on or after October 1, 1997.

Reductions to Capital Payments for Certain PPS-Exempt Hospitals and Units (Section 4412)

Provision

- Requires the Secretary to reduce capital payments for psychiatric, rehabilitation, and long-term care hospitals and distinct part units by 15% for fiscal years 1998-2002.

Effective Date

- October 1, 1997.

Rebasing (Section 4413)

Provisions

- Allows psychiatric, rehabilitation, children's, cancer and long-term care hospitals and psychiatric and rehabilitation units that received Medicare payments for services furnished during cost reporting periods beginning before October 1, 1990, the option to rebase hospital target amounts for the 12-month cost reporting period beginning during FY 1998.

- The rebased target amount is determined by using the five latest settled cost reporting periods as of August 5, 1997, updated for inflation, excluding the highest and lowest cost reporting periods, and calculating an average for the remaining three. Certain long-term care hospitals (those with costs exceeding 115% of the hospital target and a 70% disproportionate patient percentage) may elect to use the cost reporting period beginning during FY 1996 as their base year, updated to FY 1998 for inflation. For fiscal years 1999-2002, the update is the market basket.

Effective Date

- A hospitals can apply to rebase its target amount for cost reporting periods beginning during fiscal year 1998.

Cap on TEFRA Limits (Section 4414)

Provision

- Applies a cap to psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. Requires the Secretary to estimate the 75th percentile target amount for each respective category of hospitals for cost reporting periods ending during FY 1996. This amount will be updated by the MB up to the first cost reporting period

beginning on or after October 1, 1997. The cap amount will be updated by the MB for cost reporting periods beginning during each of fiscal years 1999 through 2002.

Effective Date

- Cost reporting periods beginning on or after October 1, 1997.

Bonus and Relief Payments (Section 4415)

Provisions

- Regular bonus payments equal the lesser of: (1) 15 percent of the amount by which the target amount exceeds the amount of operating costs, or (2) 2 percent of the target amount.

- Establishes a continuous improvement bonus payment system for cost reporting periods beginning on or after October 1, 1997. To be eligible in a given cost reporting period, a hospital must have received payments as a PPS-exempt facility for at least three cost reporting periods prior to the current one. In addition, the hospital's operating costs for the current period must be lower than the least of: (1) its target amount, (2) its trended costs, or (3) its expected costs.

  + "Trended cost" is the lesser of actual operating costs or the target amount in 1996, updated by the market basket increase to the current fiscal year.

  + "Expected cost" is the lesser of actual operating costs or the target amount for the previous cost reporting period, updated by the market basket increase for the current fiscal year.

  If a hospital is eligible for the continuous improvement bonus, the bonus payment is equal to the lesser of: (1) 50 percent of the amount by which operating costs are less than expected costs, or (2) 1 percent of the target amount.

- Relief payments are available to hospitals that have operating costs above 110 percent of their target amounts. If a hospital's operating costs are between 100 and 110 percent of the target, a hospital will not receive any payments beyond the target amount. Relief payments equal 50 percent of the amount by which operating costs exceed 110 percent of the target. Total relief payments cannot exceed 10 percent of the target.

- The Secretary is required to submit a report on the impact of the relief payment changes on psychiatric hospitals that have approved medical residency training programs.

Effective Date

- Effective for cost reporting periods beginning on or after October 1, 1997.

Change in Payment and Target Amount for New Providers (Section 4416)

Provision

- This provision applies to psychiatric, rehabilitation and long-term care hospitals or distinct part units in hospitals that first received Medicare payments on or after October 1, 1997. For the first two cost reporting periods for which the hospital has a settled cost report, the amount of payment equals the lesser of operating costs for that period, or 110% of the national median operating costs for hospitals in the same class for cost reporting periods ending in fiscal year 1996, wage-adjusted and updated by the MB to the fiscal year in which the hospital first received payments.

Effective Date

- For cost reporting periods beginning on or after October 1, 1997.

Treatment of Certain Long Term Care Hospitals (Section 4417)

Provisions

- A long-term care hospital which was so classified by the Secretary before September 30, 1995 will continue to be classified as a long-term care hospital even if it is located in the same building as, or on the same campus as, another hospital.

- Exempts a hospital that first received payments in 1986 which has an average inpatient length of stay greater than 20 days and that has 80% or more of its annual Medicare discharges that reflect a finding of neoplastic disease in its 12-month cost reporting period ending in fiscal year 1997.

Effective Date

- Discharges occurring on or after October 1, 1995 for the first provision; cost reporting periods beginning on or after the date of enactment for the second provision.

Treatment of Certain Cancer Hospitals (Section 4418)

Provision

- Exempts a hospital recognized as a comprehensive cancer research center by the National Cancer Institute of the National Institutes for Health as of April 20, 1983; that is located in a State which, as of December 19, 1989, was not operating a demonstration project

under Section 1814(b); that applied and was denied classification on or before December 31, 1990; is licensed for less than 50 acute care beds; and demonstrates that at least 50% of its total discharges reflect a finding of neoplastic disease for the 4-year period ending December 31, 1996. Payments are retroactive to cost reporting periods beginning on or after January 1, 1991. The hospital has the option to re-base, using 1990 costs. Retroactive payments are to be made within one year after the date of enactment.

Effective Date

- Upon enactment.

Elimination of Exemptions for Certain Hospitals (Section 4419)

Provisions

- Eliminates exemptions from target amounts for new psychiatric, rehabilitation, long-term care and cancer hospitals or units for cost reporting periods beginning on or after October 1, 1997.

- Requires the Secretary to publish a report annually in the Federal Register describing the amount of exception payments made to all hospitals during the previous fiscal year.

Effective Date

- For cost reporting periods beginning on or after October 1, 1997.

Subchapter B--Prospective Payment System for PPS-Exempt Hospitals

Prospective Payment for Inpatient Rehabilitation Hospital Services (Section 4421)

Provisions

- Requires the Secretary to establish a prospective payment system for inpatient rehabilitation hospital or unit services (operating and capital costs) based on patient case mix groups.

- Authorizes a 3- year transition period to full PPS implementation. Payment for cost reporting periods on or after October 1, 2000 and before October 1, 2002 is equal to the sum of the TEFRA rate and the PPS rate. The blend is as follows:

    + on or after October 1, 2000 and before October 1, 2001, the TEFRA percentage (or, the percentage of the amount that would have been paid if this subsection did

not apply) is 66.6 percent, and the PPS percentage (or, the product of the per unit payment rate and the number of such payment units within a cost reporting period) equals 33.3 percent.

+ on or after October 1, 2001 and before October 1, 2002, the TEFRA percentage is 33.3% and the PPS percentage is 66.6%.

o Requires the Secretary to establish classes of patients (based on factors which the Secretary deems appropriate) of rehabilitation facilities and a method of classifying specific patients within these groups. The unit of payment will be defined by the Secretary. The Secretary is authorized to adjust payments according to case mix and to require facilities to submit the necessary data in order to establish and administer the PPS under this subsection.

o The Secretary is required to determine a prospective payment rate for each payment unit for which a rehabilitation facility would be entitled to payment under Medicare. The payment rate will be determined using the most recent cost reporting data and by calculating the average payment for operating and capital costs per facility, adjusted by: (1) updating by the weighted average of the applicable percentage increases for each fiscal year up to FY 2000, and an increase factor specified by the Secretary for subsequent fiscal years; (2) reducing such rates by a factor equal to the estimated proportion of payments for Medicare outliers; (3) adjusting by area wage factors; (4) adjusting by case mix; and (5) adjusting for other factors that the Secretary deems appropriate.

+ The Secretary is required to adjust the PPS portion of the rate attributable to wage and wage-related costs by a factor reflecting the relative hospital wage level in the geographic area of the rehabilitation facility. This adjustment will be completed not later than October 1, 2001 and at least every 36 months thereafter.

+ The Secretary may provide for outlier payments based on unusual length of stay, costs or other factors specified by the Secretary. The amount of the additional payment should approximate the marginal cost of the care beyond the cutoff point and may not exceed 5% of the total PPS payments projected or estimated to be made in that year. The Secretary may make adjustments to payment amounts in order to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

o Payments under this section for fiscal years 2001 and 2002 must be budget neutral. For payment units in each fiscal year beginning with FY 2001, the Secretary is required to establish an increase factor based on an appropriate percentage increase in the market basket of goods and services comprising the services paid for under this subsection.

- The Secretary must publish in the Federal Register, on or before August 1 of each fiscal year (beginning with fiscal year 2001), the classification and weighting factors for case mix group, and a description of the data and methodology used in computing the prospective payment rates.

- There is to be no administrative or judicial review for the establishment of the case mix groups, the prospective payment rates, outlier and special payments, or the area wage adjustments.

Effective Date

- For cost reporting periods beginning on or after October 1, 2000, except that the Secretary may require submission of data on or after the date of enactment.

Development of Proposal on Payments for Long-Term Care Hospitals (Section 4422)

Provision

- Requires the Secretary to develop a legislative proposal for establishing a case-mix adjusted PPS for payment of long-term care hospitals. The Secretary is authorized to collect data from long-term care hospitals, and must submit a report to Congress detailing the proposed system.

Effective Date

- Upon enactment. The report to Congress is due not later than October 1, 1999.

SUBTITLE E--PROVISIONS RELATING TO PART A ONLY

Chapter 3--Payment for Skilled Nursing Facilities

Extension of Cost Limits (Section 4431)

Provision

- SNF routine cost limits would be based on the limits that were in effect for the previous year.

Effective Date

- For cost reporting periods beginning on or after October 1, 1997.

Prospective Payment for SNF Services (Section 4432)

Provisions

- Phases-in a prospective payment system (PPS) for skilled nursing facility (SNF) care that would pay a Federal per diem rate for SNF services. The per diem payment would cover routine, ancillary, and capital-related costs. Covered services include all items and services (other than those specifically exempted) for which payment may be made under Part B and which are furnished to an individual who is a resident of a SNF during the period in which the individual is provided covered post-hospital extended care services.

- The PPS has a 3 year phase-in period. During this period, payment is the sum of the non-Federal percentage of the facility-specific per diem and the Federal percentage of the adjusted Federal per diem rate. The payment blend is as follows:

  + For the first cost-reporting period, the non-Federal percentage is 75% and the Federal is 25%. In the second cost-reporting period, the non-Federal percentage is 50%, and the Federal is 50%. In the third cost-reporting period, the non-Federal percentage is 25% and the Federal is 75%.

- The calculation of the Federal and facility-specific rates are based on allowable costs for cost reporting periods beginning in fiscal year 1995.

  + The facility-specific base payment is determined by estimating , on a per diem basis, the total of the allowable costs of services in FY 1995 (with adjustments for non-settled cost reports) and an estimate of the amounts that would have been payable under Part B for certain services. The Secretary will take into account exception payments. The Secretary will also take into account exemptions, but only to the extent that routine costs do not exceed 150% of routine costs otherwise applicable but for the exemption. This base payment amount will be updated to the first cost-reporting period by the market basket minus 1 percentage point.

    During FY 1998-1999, this amount will be updated by the SNF market basket minus 1. During each subsequent fiscal year, the update is equal to the market basket increase for such fiscal year. Facilities involved in the Nursing Home Case-Mix and Quality Demonstration will receive the 1997 RUGS-III rate.

  + The historical Federal per diem rate is calculated (for each SNF subject to the per diem) by estimating, on a per diem basis, the total of 1995 allowable costs (not exempted from the limits) plus an estimate of the amounts that would be payable under Part B. This amount will be updated to the first cost-reporting period by the market basket minus 1 (on an annualized basis).

+ The unadjusted Federal per diem rate beginning on July 1, 1998 and ending on September 30, 1999 equals the average of the weighted average per diem for all facilities, and a weighted average per diem for freestanding facilities. This amount will be increased by the MB minus 1 percentage point.

  -- For FY 2000, this rate will be increased by the SNF MB minus 1 percentage point.

  -- For FYs 2001 and 2002, the rate of the previous fiscal year will be updated by the MB minus 1 percentage point.

  -- For each subsequent fiscal year, the update is the MB.

+ The unadjusted Federal per diem will be adjusted for case mix, case-mix creep, and for geographic variations in labor costs.

o For each fiscal year, the Secretary is required to publish in the Federal Register, prior to August 1, the unadjusted Federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustments.

o Requires payment for all Part B items and services to be made to the facility (consolidated billing). Consolidated billing requirements apply to Medicare beneficiaries residing in SNFs or facilities of which only a distinct part is a SNF. Payments for Part B services would be based on existing fee schedules established by the Secretary. A uniform coding system will be specified by the Secretary that identifies items and services furnished. Facility provider numbers are required on claims submitted by physicians.

o There will be no administrative or judicial review of: (1) Federal per diem rates, including adjustments or corrections for case mix and adjustments for variations in labor-related costs; (2) facility-specific rates; or (3) the establishment of transitional amounts.

o Requires the Secretary to develop an appropriate transition for swing-bed hospitals.

o Each SNF is required to submit resident assessment data necessary to develop the rates under this subsection using the resident assessment data instrument.

o The Secretary must establish a medical review process to examine the effects of the PPS on the quality of services. Particular emphasis is to be placed on non-routine covered services and physician services.

Effective Date

o Applies to cost-reporting periods beginning on or after July 1, 1998. Consolidated billing

applies to all items and services furnished on or after July 1, 1998.

SUBTITLE E--PROVISIONS RELATING TO PART A ONLY

Chapter 4--Provisions Related to Hospice Services

Payments for Hospice Services (Section 4441)

Provision

- The hospice prospective payment rates will be updated by the hospital market basket minus 1 percentage point for each of the fiscal years 1998 through 2002. In addition, the hospices will be required to submit such data as the Secretary requires on the costs of the care they provide for each fiscal year beginning with fiscal year 1999.

Effective Date

- Noted above.

Payment for Home Hospice Care Based on Location of Service (Section 4442)

Provision

- Hospice services will be paid based on the location where the service is provided, rather than where the service is billed (typically the urban location of the hospice agency.

Effective Date

- Effective for cost reporting periods beginning on or after October 1, 1997.

Hospice Care Benefits Period (Section 4443)

Provision

- Restructures the hospice benefit periods to include two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice interdisciplinary team would have to re-certify that the beneficiary is terminally ill at the beginning of the 60-day periods.

Effective Date

- Upon enactment.

Other Items and Services included in Hospice Care (Section 4444)

Provision

- Amends the definition of hospice care to include the existing enumerated services as well as any other item or service which is specified in a patient's plan of care and for which Medicare may pay. (Existing services include nursing care; physical, occupational and speech therapy; medical social services; home health aide and homemaker services; medical supplies and appliances; physician services, short-term patient care; and counseling.)

Effective Date

- Effective for Items and services furnished on or after April 1, 1998.

Contracting with Independent Physicians or Physician Groups for Hospice Services (Section 4445)

Provision

- Deletes physician services from a hospice's core services and allows hospices to employ or contract with physicians for their services. (Currently, hospices are required to provide directly for certain core services, including physician services.)

Effective Date

- Upon enactment.

Waiver of Certain Staffing Requirements for Hospice Care Programs in Nonurbanized Areas (Section 4446)

Provision

- The Secretary is allowed to waive requirements with regard to hospices being required to provide certain services, as long as they are not located in urbanized areas and can demonstrate to the satisfaction of the Secretary that they have been unable, despite diligent efforts, to recruit appropriate personnel. For these hospices, the Secretary could waive specifically the provision of physical or occupational therapy or speech-language pathology services and dietary counseling.

Effective Date

- Upon enactment.

Limitation on Liability of Beneficiaries for Certain Hospice Coverage Denials (Section 4447)

Provision

- Medicare's limitation of liability protection is extended to determinations that an individual is not terminally ill. (Limitation on liability: Medicare provides financial relief to beneficiaries and providers for certain services for which payment would otherwise be denied, if the beneficiary or provider did not know, and could not reasonably have known, that services would not be covered.)

Effective Date

- Upon enactment.

Extending the Period for Physician Certification of an Individual's Terminal Illness (Section 4448)

Provision

- The specific, statutory time frame for completion of physicians' certification for admission to a hospice are eliminated. Physicians now will be required to certify that a beneficiary is terminally ill at the beginning of the initial 90-day period.

Effective Date

- Upon enactment. (Section 4449 provides the date of enactment.)

SUBTITLE E--PROVISIONS RELATING TO PART A ONLY

Chapter 5--Other Payment Provisions

Reductions in Payments for Enrollee Bad Debt (Section 4451)

Provision

- Reduces allowable costs of bad debt by 25 percent in FY 1998, 40 percent in FY 1999, and 45 percent thereafter.

Effective Date

- Noted above.

Permanent Extension of Hemophilia Pass-Through Payments (Section 4452)

Provision

- Reinstates the pass-through for the cost of clotting factor provided to beneficiaries who have hemophilia that expired September 1, 1994.

Effective Date

- Upon enactment.

Reduction in Part A Medicare Premium for Certain Public Retirees (Section 4453)

Provision

- Certain public retirees would no longer have to pay the premium to receive HI benefits. Such individuals would include those: (1) receiving cash benefits under qualified state or local government retirement systems generally, or on the basis employment for at least 40 calendar quarters; (2) married for at least 1 year to one with at least 40 quarters of coverage; (3) that had been married for at least 1 year to one with at least 40 quarters of coverage before death; (4) that are divorced from (after at least 10 year of marriage) one with at least 40 quarters of coverage; and (5) those whose HI premium will not be paid (or had not been paid for the prior 84 months by a state (including Medicaid).

Effective Date

- The premium waiver begins January 1998.

- Prior months could be used to determine if an individual met the 84 month requirement.

Coverage of Services in Religious Nonmedical Health Care Institutions (Section 4454)

Provision

- Various Medicare and Medicaid requirements providing for State agency establishment and enforcement of standards and inspections have long allowed specific exceptions for Christian Science sanitoria. A recent Federal court case struck down these exceptions because they were limited to Christian Scientist sanitoria only, a violation of the Constitution.

  The new law deletes statutory references to Christian Scientist sanitoria and replaces them with the term, “religious nonmedical health care institutions.” The provision includes detailed eligibility criteria for facilities to protect the health and safety of

patients, and limits the total amount of expenditures that can be paid to the religious nonmedical health care institutions.

Effective Date

- Applies to items and services furnished on or after the date of enactment.
  - The Secretary of HHS must issue implementing regulations no later than July 1, 1998 (which may be issued as interim final).

SUBTITLE F--PROVISIONS RELATING TO PART B ONLY

Chapter 1--Services of Health Professionals

Subchapter A--Physicians' Services

Establishment of Single Conversion Factor for 1998 (Section 4501)

Provision

- Establishes a single conversion factor for 1998, based on the 1997 primary care conversion factor, updated to 1998 by the Secretary's estimate of weighted average of the current three separate updates that would occur in the absence of legislation. (In subsequent years, the single conversion factor for 1998 would be updated by the mechanism provided in section 4502).

Effective Date

- Effective for services furnished on or after January 1, 1998.

Establishing Update for Conversion Factor to Match Spending Under Sustainable Growth Rate (Section 4502)

Provision

- Establishes the update to the conversion factor for years beginning with 1999 (unless otherwise provided by law) to be the Medicare Economic Index (MEI), adjusted to match spending under a sustainable growth rate. The adjustment could not exceed the MEI by more than 3 percentage points, nor be more than 7 percentage points less than the MEI.

  The adjustment would be determined by estimating the difference between the cumulative sum of allowed expenditures for April 1, 1997 through March 31 of the year involved and

the cumulative sum of actual expenditures for April 1, 1997 through March 31 of the preceding year. This amount would be divided by the actual expenditures for the 12-month period ending March 31 of the preceding year, increased by the sustainable growth rates for the fiscal year which begins during such 12 month period. For the 12-month period ending March 31, 1997, allowed expenditures would be defined as actual expenditures for the period, as estimated by the Secretary. For a subsequent 12-month period, allowed expenditures would be defined as allowed expenditures established for the previous period, increased by the SGR for the fiscal year which begins during that 12-month period.

Effective Date

- Effective for services furnished on or after January 1, 1999.

Replacement of Volume Performance Standard with Sustainable Growth Rate (Section 4503)

Provision

- Replaces the Medicare Volume Performance Standard with a "sustainable growth rate" (SGR). The SGR for fiscal year 1998 and subsequent fiscal years would be comprised of four factors: (1) the estimate of the weighted average percentage changes in fees for all physicians' services in the fiscal year, (2) the estimated percentage change in the average number of beneficiaries enrolled in Part B (other than Medicare+Choice enrollees) from the previous fiscal year; (3) the Secretary's estimate of the percentage growth in real GDP per capita from the previous fiscal year; and (4) the Secretary's estimate of the percentage change in expenditures for all physicians' services in the fiscal year (compared to the previous fiscal year) that will result from changes in law and regulations (excluding changes in the volume and intensity resulting from changes in the update to the conversion factor). The Secretary would be required to publish the SGR not later than August 1 before each fiscal year except that the SGR for FY 1998 would be published by November 1, 1997.

Effective Date

- Effective for fiscal years beginning with 1998.

Payment Rules for Anesthesia Services (Section 4504)

Provision

- Establishes the separate conversion factor for anesthesia services at 46 percent of the single conversion factor established for other physicians' services.

Effective Date

- Effective for services furnished on or after January 1, 1998.

Implementation of Resource-Based Methodologies (Section 4505)

Provisions

- Delays implementation of resource-based practice expense relative value units (RVUs) for 1 year until 1999. Phases-in resource-based practice expense RVUs during the 4 year period 1999 through 2002, using a blend of current practice expense RVUs (75 percent in 1999, 50 percent in 2000, 25 percent in 2001) and resource-based practice expense RVUs (25 percent in 1999, 50 percent in 2000, 75 percent in 2001). In 2002, practice expense RVUs would be entirely resource-based.

- Requires the GAO to review and evaluate the Secretary's proposed rule on resource-based practice expenses and report to Congress within 6 months of enactment. GAO would be required to analyze the adequacy of the data used in preparing the rule, categories of allowable costs, methods for allocating direct and indirect expenses, potential impacts on beneficiary access and other matters related to the appropriateness of the resource-based methodology for practice expenses.

- Specifies that the Secretary develop new resource-based RVUs. In developing such RVUs, the Secretary would be required to (1) utilize, to the maximum extent practicable, generally accepted cost accounting principles which recognize all staff, equipment, supplies and expenses, not just those which can be tied to specific procedures, and use actual data on equipment utilization and other key assumptions, (2) consult with organizations representing physicians regarding methodology and data to be used, and (3) develop a refinement process to be used during each of the 4 years of the transition. The Secretary would be required to report to Congress by March 1, 1998 on the revised practice expense RVUs and issue a new proposed rule by May 1, 1998 allowing for a 90-day comment period. The proposed rule would consider impact projections comparing new proposed payment amounts on data on actual physician practice expenses and impact projections for hospital based on other specialties, geographic payment localities and urban and rural localities.

- Requires an adjustment to practice expense RVUs in 1998 which would reduce payments for high-practice expense procedures and use the savings to increase payments for office visit procedure codes. Procedures subject to the reduction would be those where practice expense RVUs currently exceed 110 percent of work RVUs and which are not performed at least 75 percent of the time in the office setting. The aggregate amount of reduction would be $390 million and procedures would not be reduced if the in-office or out-of-office practice expense RVU would increase under the Secretary's June 18, 1997

proposed rule.

- Requires implementation of resource-based malpractice relative value units, in a budget-neutral manner, for years beginning with 2000.

Effective Date

- Effective for services furnished on or after January 1, 1998 or otherwise as noted.

Dissemination of Information on High Per Discharge Relative Values for In-Hospital Physicians' Services (Section 4506)

Provision

- Requires the Secretary, for 1999 and 2001, to send to a subset of medical executive committees of hospitals identified as having excessive hospital-specific per discharge relative values for physicians' services a notice that the medical staff has excessive relative values per discharge. The Secretary is required to evaluate the responses of medical staffs notified compared to medical staffs with excessive relative values at hospitals not notified. Per-discharge relative values would be adjusted for teaching and disproportionate share status of the hospital.

Effective Date

- Upon enactment (but applicable to 1999 and 2001).

Use of Private Contracts by Medicare Beneficiaries (Section 4507)

Provisions

- Allows physicians or practitioners to sign private contracts with Medicare beneficiaries for which no claim is to be submitted to Medicare and for which the physician or practitioner receives no reimbursement from Medicare directly, on a capitated basis or from an organization which receives reimbursement under Medicare for the item or service. Services provided under private contracts would not be covered by Medicare.

- Private contracts would not be valid unless they are written and signed by the beneficiary before any item or service is provided pursuant to the contract, the contract is not entered into when the beneficiary is facing an emergency or urgent health care situation, and contains five specific items.

- The contract would need to clearly indicate to the beneficiary that by signing such contract the beneficiary: (1) agrees not submit a claim (or to request that a physician or

practitioner submit a claim) to Medicare even if the items or services would otherwise be covered, (2) agrees to be responsible, through insurance or otherwise, for payment of such items and services and understands that no reimbursement will be provided under Medicare for such items and services, (3) acknowledges that no limits (including balance billing limits) would apply to amounts that could be charged for such items or services; (4) acknowledges that Medigap plans do not, and other supplemental insurance may not, make payments for such items and services because Medicare does not make payment; and (5) acknowledges that the beneficiary has a right to have such items and services provided by other physicians or practitioners for whom payment would be made under this title. The contract would also have to clearly indicate whether the physician is excluded from Medicare.

- Private contracts would not be valid unless the physician files an affidavit with the Secretary not later than 10 days after the first contract to which the affidavit applies is entered into. The affidavit would have to identify the physician or practitioner, be in writing and signed by the physician or practitioner and provide that the physician or practitioner will not submit any claim to Medicare for any item or service provided to <u>any</u> beneficiary for two years beginning on the date the affidavit is signed.

- If a physician or practitioner knowingly and willfully submits a claim to Medicare for any item or service furnished to a beneficiary during the two year period, (1) the physician or practitioner would no longer be allowed to furnish services under private contracts for the remainder of the two year period, and (2) no Medicare payment would be made for any item or service furnished by the physician or practitioner during the remainder of the two year period.

- Requires the Secretary to report to Congress by October 1, 2001, on the effects of private contracts, including the effects of private contracts on Medicare expenditures and out-of-pocket expense of beneficiaries and the quality of services, and recommendations about whether beneficiaries should be able to enter into private contracts and if so, what legislative changes, if any, should be made to improve such contracts.

Effective Date

- Applies to contracts entered into on or after January 1, 1998.

Subchapter B--Other Health Care Professionals

Increased Medicare Reimbursement for Nurse Practitioners and Clinical Nurse Specialists (Section 4511)

Provision

- Removes the restriction on settings for services furnished by nurse practitioners (NP's) and clinical nurse specialists (CNSs). Payments would be allowed for services furnished by NPs and CNSs in all settings but only if no facility or other provider charges or is paid in connection with the service. Payment would be equal to 80 percent of the lesser of the actual charge or 85 percent of the physician fee schedule. Payment could be made directly to the NP or CNS. The definition of a CNS is clarified: a CNS must be a registered nurse licensed to practice in the state who holds a Master's degree in a defined clinical area of nursing and from an accredited educational institution.

Effective Date

- Effective for services furnished on or after January 1, 1998.

Increased Medicare Reimbursement for Physician Assistants (Section 4512)

Provision

- Removes the restriction on settings and services furnished by physician assistant (PAs). Payments would be allowed for services furnished by PAs in all settings but only if no facility or other provider charges or is paid in connection with the service. Payment would be equal to 80 percent of the lesser of the actual charge or 85 percent of the physician fee schedule. Allows payment to a PA as an independent contractor to qualify as an employment relationship (since PA payment is made only to the employer).

Effective Date

- Effective for services furnished on or after January 1, 1998.

No X-Ray Required for Chiropractic Services (Section 4513)

Provisions

- Eliminates the statutory requirement for a subluxation to be demonstrated by an x-ray before Medicare would pay for manual manipulation of the spine to correct a subluxation.

- Requires the Secretary to develop and implement utilization guidelines relating to the coverage of chiropractic services in cases in which a subluxation has not been demonstrated by x-ray to exist.

Effective Date

- Effective for services furnished on or after January 1, 2000.

SUBTITLE F--PROVISIONS RELATING TO PART B ONLY

Chapter 2--Payment for Hospital Outpatient Department Services

Elimination of Formula-Driven Overpayment (FDO) for Certain Outpatient Hospital Services (Section 4521)

Provision

- Eliminates the formula-driven overpayment that hospitals now receive for surgery, radiology and other diagnostic services furnished in outpatient departments by allowing Medicare to deduct the full amount of beneficiary coinsurance payments from the Medicare payment amount.

Effective Date

- Effective for services furnished on or after October 1, 1997.

Extension of Reductions in Payments for Costs of Hospital Outpatient Services (Section 4522)

Provision

- Extends through calendar year 1999 the following two provisions that would otherwise expire at the end of 1998:
  - the 10 percent reduction in payments for hospital outpatient capital; and
  - the 5.8 percent reduction for outpatient services paid on a cost basis.

Effective Date

- Upon enactment.

Prospective Payment System for Hospital Outpatient Department Services (Section 4523)

Provision

- Prospective Payment System--A prospective payment system (PPS) for hospital outpatient department (OPD) services will be implemented on January 1, 1999. Services included under the PPS will be: (1) OPD services designated by the Secretary (but not including therapy services and ambulance services, which will be paid on the basis of fee schedules); and (2) services covered under part B that are provided to hospital inpatients

who have exhausted Part A benefits or are not entitled to Part A.

- o System Requirements--The Secretary will develop a classification system consisting of groups of services so that services within each group are comparable clinically and with respect to the use of resources. The Secretary will establish relative payment weights for each group based on median hospital costs and estimated frequencies of utilization of services in 1999. The Secretary will also establish a wage adjustment factor as well as other adjustments determined to be necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals.

- o Calculation of OPD Fee Schedule Amounts--The OPD fee schedule amounts in 1999 will be determined in the following way:

  - + The Secretary will estimate the sum of: (1) the total amount that would otherwise be paid by Medicare for OPD services in 1999; and (2) the total amount of copayments that are estimated to be paid under the provisions of this new section, as described below.

  - + A conversion factor will be estimated in order to convert the weights into fee schedule amounts. This conversion factor will be calculated in a manner so that the sum of the products of the fee schedule amounts and the frequencies equals the aggregate sum of Medicare payments and copayments estimated above. [Note: Since the formula-driven overpayment is eliminated on October 1, 1997 and the cost and capital reductions on OPD services are being extended, these two provisions will be built into the base OPD fee schedule rates in 1999.]

  - + For each group, the OPD fee schedule amount will equal the conversion factor multiplied by the weight.

- o Calculation of Base Copayment Amounts--An "unadjusted copayment amount" will be established for each OPD group based on 20 percent of the national median of the charges for services in the group furnished during 1996, and updated to 1999 using the Secretary's estimate of charge growth. If the unadjusted copayment amount results in an amount that is less than 20 percent of the OPD fee schedule amount, then the copayment amount will be established to be 20 percent of the OPD fee schedule amount.

- o Calculation of Pre-Deductible Payment Percentage--A pre-deductible payment percentage will be calculated for each group in each year. This will be equal to the ratio of: (1) the OPD fee schedule amount minus the unadjusted copayment amount; to (2) the OPD fee schedule amount.

- o Calculation of Medicare Payments and Copayments for each Group--To determine payment for a particular group in a particular area, the following calculation will occur:

(1) The OPD fee schedule amount for the group will be adjusted by the wage adjustment factor and other factors determined to be necessary by the Secretary.

(2) The Medicare portion of the OPD fee schedule amount will be equal to the adjusted OPD fee schedule amount multiplied by the pre-deductible payment percentage .

(3) The amount of beneficiary copayment will be equal to the adjusted OPD fee schedule amount in (1) minus the Medicare portion of the payment calculated in (2).

Note that if a beneficiary has not met the full portion of the Part B deductible, the amount of unmet deductible is subtracted from the adjusted OPD fee schedule amount after step (1) above.

- Calculation of Payments in Subsequent Years--In future years, the conversion factor used to determine the OPD fee schedule amounts will be updated by the hospital market basket, except that for 2000, 2001, and 2002, the update will be equal to the hospital market basket reduced by 1 percentage point.

  In each year, the unadjusted copayment amount remains unchanged. The pre-deductible payment percentage and the Medicare payment, however, will continue to be calculated in the same manner, and Medicare will assume a larger portion of the total OPD fee schedule amount each year. At the point in time when the copayment amount for a group equals 20 percent of the OPD fee schedule amount, the copayment amount will be maintained each year at 20 percent of the fee schedule.

- Election to Offer Reduced Copayment Amount--The Secretary is required to establish a procedure whereby a hospital could elect to reduce the copayment amount for some or all OPD services to a lower amount (but not less than 20 percent of the fee schedule amount).

- Periodic Review and Adjustment to PPS--The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. Such adjustments must be made in a budget neutral fashion.

- Volume Adjustment--The Secretary is required to develop a method for controlling unnecessary increases in the volume of services. If the Secretary determines under such a methodology that the volume of services has increased beyond amounts established through such methodology, the Secretary may adjust the update to the conversion factor.

- Cancer Hospitals--For cancer hospitals, the PPS for OPD services shall not apply until January 1, 2000. The Secretary may establish a separate conversion factor for services furnished by these hospitals in a manner that specifically takes into account the unique costs incurred by them by virtue of their patient population and service intensity.

- Limitation on Review--There shall be no administrative or judicial review of the development of the classification system, including the establishment of groups and relative payment weights, wage adjustment factors, other adjustments, and volume performance methodologies, the calculation of base amounts, periodic adjustments, and the establishment of a separate conversion factor for cancer hospitals.

Effective Date

- Upon enactment.

SUBTITLE F--PROVISIONS RELATING TO PART B ONLY

Chapter 3--Ambulance Services

Payments for Ambulance Services (Section 4531)

Provisions

- Sets interim payment reductions for period prior to implementation of a fee schedule. Payments based on reasonable costs per ambulance trip (for hospital-based ambulances and services provided under arrangement with a hospital) and reasonable charges (for independent suppliers) may not exceed costs or charges recognized in prior year increased by the CPI-U minus 1 percentage point. These reductions would apply in FYs 1998, 1999, and 2000 prior to January 1, 2000 for cost-based payments, and in calendar years 1998 and 1999 for charge-based payments.

- Requires the Secretary to establish a fee schedule for ambulance services by January 1, 2000 based on specified considerations through negotiated rulemaking. The fee schedule will apply to all ambulance services whether provided by an independent supplier, a hospital, or under arrangement with a hospital. Payment in 2000 may not exceed aggregate payment that would have been made without the fee schedule but with the interim payment reductions (CPI-U minus 1 percentage point) set by this section in place and continued through 2002. Payment increases in subsequent years would be tied to the CPI-U.

- Requires suppliers of ambulance services to accept assignment (i.e. to accept Medicare's approved payment amount as payment in full).

- Authorizes the Secretary to pay directly for advanced life support (ALS) services provided in rural areas by paramedics under contract with a certified volunteer ambulance company. The volunteer company must provide only basic life support (BLS) services, and be prohibited by state law from billing for any services. The ALS company must be certified under Medicare and must bill all recipients (not just Medicare) for ALS intercept services.

Effective Date

- Interim payment reductions for cost-based ambulance services apply October 1, 1997 through December 31, 1999. Interim payment reductions for charge-based ambulance services apply January 1, 1998 through December 31, 1999. Fee schedule is to be effective January 1, 2000. Paramedic intercept payment is discretionary and would be effective as designated in regulations promulgated by the Secretary.

Demonstration of Coverage of Ambulance Services Under Medicare Through Contracts With Units of Local Government (Section 4532)

Provisions

- Requires the Secretary to establish up to 3 demonstration projects by entering into contracts with a unit of local government to furnish ambulance services on a capitated payment basis. The contract must cover at least 80 percent of the persons residing within the unit of local government who are enrolled in Medicare Part B (but not in a Medicare+Choice plan). Each project may last up to 3 years.

- In the first year of a contract, per capita payments would equal 95% of the average annual per capita payment made for individuals covered by the contract in the most recent 3 years for which data are available. In subsequent years, payment would equal 95% of the amount established for the prior year, increased by the CPI-U.

- The contracts may allow for coverage of persons residing in additional units of local government, for transport to non-hospital providers if quality services can be furnished at lower cost, and for implementation of other innovations to improve quality and control costs.

- Requires the Secretary to evaluate the demonstration projects and report to Congress by January 1, 2000, including possible recommendations to modify the payment method, and whether to extend or expand the demonstration projects.

Effective Date

- The dates of demonstration projects would be set by contract and may last for up to 3

years. The report to Congress evaluating the projects is due January 1, 2000.

SUBTITLE F--PROVISIONS RELATING TO PART B ONLY

Chapter 4--Prospective Payment for Outpatient Rehabilitation Services

Prospective Payment for Outpatient Rehabilitation Services (Section 4541)

Provisions

- o Payment Based on Fee Schedule
  - + This provision applies to outpatient physical therapy, occupational therapy, and speech-language pathology services covered under Part B and furnished by the following providers: rehabilitation agencies, public health agencies, clinics, skilled nursing facilities, home health agencies (to individuals who are not homebound), hospitals, and other entities under an arrangement with any of the listed entities. The provision also applies to all services furnished by comprehensive outpatient rehabilitation facilities (CORFs).
  - + In 1998, for these listed services (with the exception of therapy services furnished by hospitals), payment will be based on the lower of charges or the reasonable cost, reduced by 10 percent, minus the amount of coinsurance (which is based on 20 percent of charges). Therapy services furnished by hospitals will continue to be paid under the rules established for payment of outpatient department services in 1998.
  - + In 1999, for all the listed services, payment will be 80 percent of the lower of charges or the amount paid under the physician fee schedule. Coinsurance will be 20 percent of such an amount.
  - + These therapy services will be subject to mandatory assignment.
  - + Claims for these services submitted on or after April 1, 1998 will be required to include a code under a uniform coding system specified by the Secretary identifying the services furnished.
- o Application of Standards to Outpatient Occupational and Physical Therapy Services Provided Incident to a Physician's Professional Service--Outpatient physical therapy, occupational therapy, and speech-language pathology services furnished incident to a physician's professional services will be required to meet the standards and conditions (other than any licensing requirement specified by the Secretary) that apply to therapists

in independent practice.

- o Applying Financial Limitation to all Rehabilitation Services

  - + Beginning on January 1, 1999, an annual per beneficiary limit of $1500 will apply to all outpatient physical therapy services (including speech-language pathology services) except for services furnished by a hospital outpatient department. A separate $1500 limit will also apply to all outpatient occupational therapy services except for services furnished by hospital outpatient departments. Therapy services furnished incident to a physician's professional services will also be subject to these limits.

  - + Beginning with 2002, these $1500 limits will be increased by the percentage increase in the Medical Economic Index.

  - + By January 1, 2001, the Secretary must submit a report to Congress recommending a revised coverage policy for outpatient physical therapy, occupational therapy and speech-language pathology services in place of the $1500 limitation. This coverage policy is to be based on a classification of individuals by diagnostic category and prior use of services. The report should include recommendations on how such durational limits by diagnostic category could be implemented in a budget-neutral manner.

Effective Dates

- o The payment provisions are effective on January 1, 1998, with the exception of payment for therapy services furnished by hospital outpatient departments, which is effective on January 1, 1999.

- o Application of the standards for therapy services in physician offices is effective on January 1, 1998.

- o Application of the $1500 limits to outpatient therapy services is effective on January 1, 1999.

SUBTITLE F--PROVISIONS RELATING TO PART B ONLY

Chapter 5--Other Payment Provisions

Payments for Durable Medical Equipment (Section 4551)

Provisions

- o DME Updates--The updates for DME are reduced to zero percentage points for each of the years 1998 through 2002.

- o P&O Updates--The updates for prosthetics and orthotics is reduced to 1 percent for each of the years 1998 through 2002.

- o PEN Payments--Payments for parenteral and enteral nutrients are frozen at 1995 levels for the period 1998 through 2002 and for a subsequent year the CPI-U.

- o DME Upgrades--Upon the effective date of regulations issued by the Secretary, a DME supplier would be permitted to provide an upgraded DME item to a beneficiary, receive direct payment from Medicare and collect the difference between the Medicare payment and the supplier's cost of the upgraded item from the beneficiary. Any regulations established by the Secretary must contain consumer protection standards.

Effective Date

- o Upon enactment. The DME upgrade provision would apply to purchases and rentals after the effective date of any regulations issued by the Secretary.

Oxygen and Oxygen Equipment (Section 4552)

Provisions

- o Payments for Oxygen--For 1998, the national payment limit for oxygen and oxygen equipment is the 1997 limit reduced by 25 percent. For 1999 and each subsequent year, the national payment limit is the 1997 limit reduced by 30 percent.

- o Classes of Payments--The Secretary could create different categories of oxygen equipment with differing payment amounts as long as there is no net increase in payments for oxygen.

- o Standards for Oxygen Providers--The Secretary would establish service standards for oxygen providers.

- o GAO Report and PRO Evaluation--The GAO would report within 18 months of enactment on access to oxygen equipment. The Secretary is to arrange with PROs to evaluate access and quality of oxygen equipment following enactment.

Effective Date

- o Provisions related to payments for oxygen equipment and services are effective on or after January 1, 1998. All other provisions are effective upon enactment.

Reduction in Updates to Payment Amounts for Clinical Diagnostic Laboratory Tests; Study on Laboratory Tests (Section 4553)

Provision

- Freezes fee schedule payments for 1998 through 2002. Lowers national payment cap from 76% to 74% of the median of all fee schedules, beginning in 1998. Directs the Secretary to request a study by the Institute of Medicine on Part B payment for clinical laboratory tests addressing the adequacy of current payment methodology, recommendations for alternative payment systems, and the relationship between payment systems, access and quality (including access to new technologies). A report on the study is to be submitted to Congress within 2 years of enactment.

Effective Date

- The fee schedule freeze is effective January 1, 1998 through December 31, 2002. The national payment cap is lowered effective January 1, 1998.

Improvements in Administration of Laboratory Tests Benefit (Section 4554)

Provisions

- Requires the Secretary to designate up to 5 regional carriers to process laboratory claims by July 1, 1999, with one carrier designated as a central statistical resource for such claims. Claims would be allocated to carriers based on where the specimen was collected or by another method specified by the Secretary. Physician office labs would be excluded from regional claims processing if the Secretary determines that such labs would be unduly burdened by having to bill more than one carrier.

- Requires the Secretary to adopt, beginning January 1, 1999, national coverage and administrative policies for lab tests through negotiated rulemaking. The regional carriers may collectively develop interim national policies, effective for up to 2 years. Carriers may also implement interim regional policies before the first national policies are established, or thereafter in cases where no national policy exists and there is a demonstrated need for a policy to respond to aberrant or unnecessary utilization of tests. Such policies may last for up to 2 years (or longer if explicitly allowed by the Secretary). The Secretary must solicit comments and review the national policies at least every 2 years.

- Requires carrier advisory committees to include a member representing independent clinical laboratories (and other labs as the Secretary deems appropriate). Recommendations from national and local organizations representing independent

clinical laboratories will be considered in selecting such a member.

Effective Date

- Claims processing by regional specialty carriers for lab tests to begin by September 1, 1999. First national coverage policies to be adopted by January 1, 1999.

Updates for Ambulatory Surgical Services (Section 4555)

Provision

- For each of the fiscal years 1998 through 2002, the increase in payment for ambulatory surgical centers will be equal to the percentage increase in the consumer price index reduced by 2 percentage points.

Effective Date

- Upon enactment.

Reimbursement for Drugs and Biologicals (Section 4556)

Provision

- Establishes payment for drugs and biologicals not paid on a cost or prospective rate basis to be equal to the lesser of the actual charge or 95 percent of the average wholesale price. The Secretary is authorized to pay a dispensing fee (less applicable deductible and coinsurance amounts) to a pharmacy if payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under Part B.

- Requires the Secretary to study and report to Congress by July 1, 1999 on the effects of this amendment on the average wholesale price of drugs and biologicals.

Effective Date

- Drugs and biologicals furnished on or after January 1, 1998.

Coverage of Oral Anti-Nausea Drugs Under Chemotherapeutic Regimen (Section 4557)

Provision

- Provides coverage, under specified conditions, for an oral drug used as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen. It would have to be administered by a physician (or as prescribed by a physician) for use immediately before,

at, or within 48 hours after the time of administration of the chemotherapeutic agent and used as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.

Effective Date

- Applies to services furnished on or after January 1, 1998.

Renal Dialysis-Related Services (Section 4558)

Provision

- Requires the Secretary, beginning with cost reports for 1996, to audit cost reports for each renal dialysis provider at least once every three years.

- Requires the Secretary to develop and implement a method to measure and report on the quality of renal dialysis services provided under Medicare.

Effective Date

- Develop quality report measure by January 1, 1999; implement quality measure and report by January 1, 2000.

Temporary Coverage Restoration for Portable Electrocardiogram Transportation (Section 4559)

Provision

- Restores separate payment for 1 year (1998) for transportation of EKG equipment based on the payment method in effect on December 31, 1996. By not later than July 1, 1998, the Secretary is required to make a recommendation to Congress as to whether portable EKG transportation should be covered under Medicare. In making the recommendation, the Secretary is required to take into account the study of coverage of portable EKG conducted by GAO and other relevant information. (Further Congressional action would be needed to extend payment for EKG transportation after 1998.)

Effective Date

- Effective for services furnished during 1998.

SUBTITLE F--PROVISIONS RELATING TO PART B ONLY

Chapter 6--Part B Premium and Related Provisions

Subchapter A--Determination of Part B Premium Amount

Part B Premium (Section 4571)

Provision

- The Part B premium is permanently set at 25 percent of program costs.

Effective Date

- Upon enactment.

Subchapter B--Other Provisions Related to Part B Premium

Protections Under the Medicare Program for Disabled Workers Who Lose Benefits Under a Group Health Plan (Section 4581)

Provisions

- Certain disabled beneficiaries will be eligible for a special enrollment period and waiver of the part B premium surcharge. These individuals will be those disabled beneficiaries who:
  - + were enrolled in a group health plan (by reason of current or former employment or the current or former employment of a family member) at the time of initially becoming eligible for Medicare;
  - + who elected not to enroll in Part B during their initial enrollment period; and
  - + whose continuous enrollment under the group health plan is involuntarily terminated at a time when the enrollment is by reason of the individual's former employment (or the former employment of a family member).

  The special enrollment period will begin on the first day of the month that includes the date of the involuntary termination and last for six months.

Effective Date

- Effective for involuntary terminations of coverage under a group health plan occurring on or after the date of enactment.

Governmental Entities Eligible to Elect to Pay Part B Premiums for Eligible Individuals (Section 4582)

Provision

- Upon the request of any appropriate State or local governmental entity specified by the Secretary, the Secretary could enter into an agreement whereby the State or local governmental entity agrees to pay, on a quarterly or other periodic basis, to the Secretary an amount equal to the total part B late enrollment surcharge amounts for a group of individuals chosen by such an entity. [Note: Current law only allows States to enter into such agreements.]

Effective Date

- Upon enactment.

SUBTITLE G--PROVISIONS RELATING TO PARTS A AND B

Chapter 1--Home Health Services and Benefits

Subchapter A--Payments for Home Health Services

Recapturing Savings from the OBRA 1993 Freeze on Payment Increases for Home Health Services (Section 4601)

Provision

- The Secretary will establish the revised home health per visit cost limits in a manner that recaptures the savings associated with the OBRA 1993 temporary freeze on cost limit updates.

Effective Date

- Cost reporting periods beginning after September 30, 1997.

Interim Payments for Home Health Services (Section 4602)

Provision

- Home health per visit cost limits are reduced from 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies to 105 percent of the median of such costs. In addition, home health agencies will be paid the lowest of: (1) actual costs;

(2) the per visit limits; (3) a blended, agency-specific per beneficiary annual limit. For beneficiaries using more than one home health agency, the per beneficiary limitation would be prorated among the agencies.

Effective Date

- Services furnished on or after October 1, 1997.

Establish a Prospective Payment System (Section 4603)

Provision

- A prospective payment system for all home health services must be developed and implemented. In developing the PPS, the Secretary must consider an appropriate unit of service, the number of visits provided within that unit, and their cost. Payment for a unit of home health service will be modified by a case mix adjustor, set by the Secretary, to explain a significant amount of the variation in the cost of different units of service. Upon implementation of PPS, periodic interim payments (PIP) will be eliminated. Home health agencies will be required to bill for all services (including contracted services). All payments will be made to the agency directly.

Effective Date

- Effective for cost reporting periods beginning on or after October 1, 1999.

Payment Based on Location of Service (Section 4604)

Provision

- Home health services will be paid based on the location where the service is provided (in the patient's home), rather than where the service is billed (typically the urban location of the parent home health agency.

Effective Date

- Cost reporting periods beginning on or after October 1, 1997.

Subchapter B--Home Health Benefits

Creation of Separate Part A and Part B Home Health Benefits (Section 4611)

Provision

- Home health services unassociated with a hospital or skilled nursing facility stay will be gradually transferred from Part A to Part B. Medicare Part A will continue to cover the first 100 visits following a 3-day hospital stay or a skilled nursing facility stay. The transfer will phase in over a 6-year period, while the cost of the home health services transferred will phase in to the Part B premium over 7 years.

Effective Date

- Services furnished on or after January 1, 1998.

Clarification of Part-Time or Intermittent Nursing Care (Section 4612)

Provision

- Clarifies the current limits on the number of hours and days home health care can be provided. "Part-time" is skilled nursing and home health aide services (combined) furnished any number of days per week, for less than 8 hours per day and 28 or fewer hours per week. "Intermittent" is skilled nursing care provided on fewer than 7 days each week, or less than 8 hours each day (combined) for 21 days or less.

Effective Date

- Services furnished on or after October 1, 1997.

Study on the Definition of Homebound (Section 4613)

Provision

- The Secretary is required to conduct a study on the criteria for determining whether an individual is homebound. A report on the study's findings must be submitted to Congress.

Effective Date

- The report is due by October 1, 1998.

Authority to Make Payment Denials Based on Normative Standards (Section 4614)

Provision

- Provides the authority to make payment denials based on normative utilization standards based on experience. The standards also would allow for the comparison of home health utilization across agencies providing similar services to beneficiaries. Home health

agencies providing significantly more services than the norm would be subject to payment denials.

Effective Date

- For services furnished on or after October 1, 1997.

No Home Health Benefits Based Solely on Drawing Blood (Section 4615)

Provision

- Venipuncture (drawing of blood for the purpose of obtaining a blood sample) will be excluded from the eligibility criteria for intermittent skilled nursing services, under the home health benefit. If venipuncture for the purpose of obtaining a blood sample is the only skilled service that is needed by the beneficiary, that individual will not qualify for home health.

Effective Date

- For services furnished six months after enactment.

Reports to Congress on Home Health Cost Containment (Section 4616)

Provision

- The Secretary must submit a report to the House Committees on Commerce and Ways and Means, and the Senate Finance Committee, that includes an estimate of the outlays expected under Part A and Part B for home health services during the fiscal years 1998 through 2002. The Secretary must also submit another annual report that compares the actual expenditures on home health to the estimated outlays. If the Secretary finds that the actual expenditures were greater than the estimated outlays, the annual report must include recommendations to reduce expenditure growth, such as beneficiary copayments or other methods.

Effective Date

- Reports are due annually for the years 1999 through 2002.

SUBTITLE G--PROVISIONS RELATING TO PARTS A AND B

Chapter 2--Graduate Medical Education

Subchapter A--Indirect Medical Education

Indirect Graduate Medical Education Payments (Section 4621)

Provisions

- Reduces the indirect teaching adjustment factor from 7.7 percent in FY 1997 to 7.0 percent in FY 1998, 6.5 percent in FY 1999, 6.0 percent in FY 2000, and 5.5 percent in FY 2001 and thereafter.

- Establishes a hospital-specific cap on the number of residents and a hospital-specific cap on the ratio of residents to beds based on the number of residents in the hospital in the most recent cost reporting period ending on or before December 31, 1996.

- The number of residents for IME payment purposes will be based on a three-year rolling average, except for FY 1998, when a two-year average will be used.

- Hospitals may include residents in non-hospital settings in their IME calculation as long as the hospital continues to pay the bulk of the residents' training costs.

Effective Date

- FY 1998

Payment to Hospitals of Indirect Medical Education Costs for Medicare Choice Enrollees (Section 4622)

Provision

- Allows for IME payments to teaching hospitals for Medicare+Choice discharges. The IME payment will be based on the same formula as for fee-for-service beneficiaries, phased-in over 5 years (20% in CY 1998, 40% in CY 1999, 60% in CY 2000, 80% in CY 2001, and 100% in CY 2002 and thereafter).

Effective Date

- CY 1998

Subchapter B--Direct Graduate Medical Education

Limit on Number of Residents and Rolling Average FTE Count (Section 4623)

Provision

- Establishes a hospital-specific cap on the number of residents based on the number of residents in the hospital in the most recent cost reporting period ending on or before December 31, 1996.

- The number of residents for direct graduate medical education payment purposes will be based on a three-year rolling average, except for FY 1998, when a two-year average will be used.

Effective Date

- FY 1998

Payments to Hospitals for Direct Cost of Graduate Medical Education of Medicare Choice Enrollees (Section 4624)

Provisions

- Provides hospitals with additional direct GME payments for Medicare+Choice discharges.

- Payments for Medicare+Choice enrollees will be determined by the same methodology as for fee-for-service beneficiaries, phased-in over 5 years (20% in CY 1998, 40% in CY 1999, 60% in CY 2000, 80% in CY 2001 and 100% in CY 2002).

Effective Date

- CY 1998

Permitting Payment to Nonhospital Providers (Section 4625)

Provisions

- The Secretary may pay nonhospital providers for their direct costs of medical education. Nonhospital providers include Federally qualified health centers (FQHCs), rural health clinics (RHCs), Medicare+Choice organizations, and any other provider as determined by the Secretary.

- The payment methodology for GME payments to nonhospital providers will be developed by the Secretary.

Effective Date

- FY 1998

Incentive Payments Under Plans for Voluntary Reduction in Number of Residents (Section 4626)

Provision

- Creates a program to assist hospitals in their efforts to downsize. Hospitals that agree to reduce the size of their residency programs by 20-25 percent over 5 years while maintaining the level of primary care training will be entitled to a certain level of hold-harmless payments over those 5 years.

Effective Date

- Within 6 months of enactment.

Medicare Special Reimbursement Rule for Primary Care Combined Residency Programs (Section 4627)

Provision

- Extends the direct graduate medical education payment for an additional yearfor combined residency programs of primary care. OB-GYN programs that are combined with primary care programs would also be eligible under this policy.

Effective Date

- July 1, 1997.

GME Consortia Demonstration (Section 4628)

Provisions

- Requires the Secretary to establish a demonstration project under which payments would be made to a consortia instead of making payments to teaching hospitals.

- Defines consortia as a teaching hospital with one or more of the following: a medical school, another teaching hospital which may be a children's hospital, an FQHC, a medical group practice, a managed care entity, an entity furnishing outpatient services or other entities authorized by the Secretary.

- The consortia will determine among its members the division of payment. The total payment to the consortia cannot exceed the direct graduate medical education payment that would have gone to the entities in the consortia.

Effective Date

- No date by which the demonstration must be established.

Recommendations on Long-Term Policies Regarding Teaching Hospitals and Graduate Medical Education (Section 4629)

Provisions

- Requires the Medicare Payment Advisory Commission (MedPAC) to examine and develop recommendations on whether, and to what extent, Medicare payment policies regarding teaching hospitals and graduate medical education should be reformed.

Effective Date

- The report is to be submitted to the Congress no later than 2 years after enactment.

Study of Hospital Overhead and Supervisory Physician Components of Direct Medical Education Costs (Section 4630)

Provision

- Requires the Secretary to conduct a study on variations among hospitals in hospital overhead and supervisory physician components in their direct medical education costs.

Effective Date

- The report to Congress is due no later than 1 year after enactment.

SUBTITLE G--PROVISIONS RELATING TO PARTS A AND B

Chapter 3--Provisions Relating to Medicare Secondary Payer

Permanent Extension and Revisions of Certain Secondary Payer Provisions (Sec 4631)

Provision

- Makes permanent 2 provisions in current law: (1) HCFA/IRS/SSA data match program; (2) Medicare secondary payer for disabled beneficiaries in large group health plans; Makes permanent and extends Medicare secondary payer for ESRD beneficiaries from the first 12 months to 30 months.

Effective Date

- Upon enactment.

Clarification of Time and Filing Limitations (Section 4632)

Provision

- Permits recovery of MSP incorrect payments within 3 years after the date of service.

Effective Date

- Upon enactment.

Permitting Recovery Against Third Party Administrator (Section 4633)

Provisions

- Permits recovery of MSP incorrect payments from TPAs of primary plans except in cases where the TPA would not be able to recover from the employer or plan due to insolvency or bankruptcy or where the TPA is not employed by or under contact with the employer at the time the recovery action is initiated.

- Limits liability of Medicare beneficiaries for incorrect Medicare payments in group health plan MSP situations unless payments were made to the beneficiary.

Effective Date

- Upon enactment.

SUBTITLE G--PROVISIONS RELATING TO PARTS A AND B

Chapter 4--Other Provisions

Placement of Advance Directive in Medical Record (Section 4641)

Provision

- Requires that the patient's advance directive be placed in a prominent part of his/her medical record.

Effective Date

- For provider agreements entered into, renewed, or extended on or after such a date as specified by the Secretary (but no later than 1 year after the date of enactment).

Increased Certification Period for Certain Organ Procurement Organizations (Section 4642)

Provision

- For certain organ procurement organizations that perform well, the Secretary may extend automatically the certification period by two years.

Effective Date

- Upon enactment.

Office of the Chief Actuary in the Health Care Financing Administration (Section 4643)

Provision

- Establishes a position of Chief Actuary in the Health Care Financing Administration. The Chief Actuary will be appointed by and report directly to the Administrator. The Chief Actuary can be removed only for cause.

Effective Date

- Upon enactment.

Conforming Amendments to Comply with Congressional Review of Agency Rulemaking (Section 4644)

Provision

- Changes the publication dates for the PPS rule. Beginning with the FY 1999 update, the PPS proposed rule must be published by April 1 and the final rule by August 1 of each year.

- As a conforming change, the deadline for applications for geographic reclassifications for years beginning with FY 2000 is moved from October 1 to September 1.

- For the FY 1998 PPS Rule, the period of Congressional review is shortened from 60 days to 30 days.

Effective Date

o Upon enactment.

SUBTITLE H -- MEDICAID

Chapter 1 - Managed Care

State Option of Using Managed Care; Change in Terminology (Section 4701)

Section 4701 of the Balanced Budget Act of 1997 adds a new section 1932 to title XIX of the Social Security Act affecting Medicaid managed care, including:

+ State Option to Use Managed Care
+ Treatment of Certain County-Operated health Insuring Organizations
+ Process for Enrollment and Termination
+ Default Enrollment Process
+ Provision of Information

These are described below.

"Section 1932(a)(1)(2)(3) State Option to Use Managed Care"

Provision

o Under section 1932(a), a State can restrict choice by offering a choice between at least two managed care organizations or Primary Care Case Managers (PCCM), or at least one plan and one PCCM. In rural areas, an individual who is offered no alternative to a single entity or manager is given a choice between at least two physicians or case managers within the entity, and permits the individual in appropriate circumstances to seek services outside the entity. Special needs children, Medicare beneficiaries, and enrolled members of Federally-recognized American Indian tribes are exempt from mandatory managed care under section 1932(a).

Effective Date

o This section applies to contracts entered into on and after October 1, 1997.

"Section 1932(a)(3)(C) Treatment of Certain County-Operated Health Insuring Organizations"

Provision

o A State is considered to meet the requirement concerning choice of plans if the managed

care entity is a health-insuring organization which became operational before January 1, 1986, or is described in section 4734 of OBRA-90, and the individual is given a choice between at least two providers within such entity.

Effective Date

- Contracts entered into on and after October 1, 1997.

"Section 1932(a)(4) Process for Enrollment and Termination"

Provision

- The State must permit individuals to change their enrollment for cause at any time, without cause within 90 days of notification of enrollment, and without cause at least every 12 months thereafter.

Effective Date

- Contracts entered into on and after October 1, 1997.

"Section 1932(a)(4)(D) Default Enrollment Process"

Provision

- States are required to establish a default enrollment process that takes into consideration maintaining existing provider-beneficiary relationships or relationships with providers that have traditionally served Medicaid beneficiaries. States must then consider ensuring equitable distribution among all other plans if those providers are not available.

Effective Date

- Contracts entered into on and after October 1, 1997.

"Section 1932(a)(5) Provision of Information"

Provision

- Each State, broker, or managed care entity must provide all notices and information in a manner which may be easily understood by enrollees and potential enrollees. Required information from the entity includes its providers, enrollees rights and responsibilities, grievance procedures, and covered items and services. States are required, annually and upon request, to provide a list identifying the managed care entities that are available and information relating to benefits, service areas, and quality and performance indicators.

States must inform the enrollee of any benefits that the enrollee may be entitled to but which are not made available through such entity.

Effective Date

- Contracts entered into on and after October 1, 1997.

Primary Care Case Management Services as State Option Without Need for Waiver (Section 4702)

Provision

- In a Primary Care Case Management (PCCM) contract, the PCCM must provide for: reasonable hours, 24 hour availability of information, referral, and treatment with respect to emergencies; restricting enrollment to individuals residing near a service site; arrangements with a sufficient number of physicians to ensure prompt and quality service; no discrimination based on health status; and a right for an enrollee to terminate without cause for the first 90 days and at least every 12 months thereafter.

Effective Date

- Contracts entered into on and after October 1, 1997.

Elimination of 75:25 Restriction on Risk Contracts (Section 4703)

Provision

- The 75/25 Medicaid beneficiary to commercial enrollee mix requirement for managed care organizations is repealed.

Effective Date

- Applies to contracts on and after June 20, 1997.

Increased Beneficiary Protections (Section 4704)

Section 4704 added the protections for beneficiaries in managed care, including:

+ Assuring Coverage of Emergency Services
+ Protection of Enrollee-Provider Communications
+ Grievance Procedures
+ Demonstration of Adequate Capacity and Services
+ Protecting Enrollees Against Liability for Payment

+ Antidiscrimination

These are described below.

"Section 1932(b)(2) Assuring Coverage to Emergency Services"

Provision

- Using the prudent lay person standard, each contract with a managed care entity must require coverage of emergency services without regard to prior authorization and comply with Medicare guidelines for post-stabilization care.

Effective Date

- Contracts entered into on and after October 1, 1997.

"Section 1932(b)(3) Protection of Enrollee-Provider Communications"

Provision

- A managed care organization must not prohibit or restrict a health care professional from advising a beneficiary about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the contract, if the professional is acting within the lawful scope of practice. The preceding clause must not be construed as requiring a managed care organization to provide coverage of a counseling or referral service if it objects to the service on moral or religious grounds; and makes available information on its policies to prospective enrollees and to enrollees within 90 days after the date the organization adopts a change in policy regarding such a counseling or referral service.

Effective Date

- Contracts entered into on and after October 1, 1997.

"Section 1932(b)(4) Grievance Procedures"

Provision

- Each managed care organization must establish an internal grievance procedure under which an enrollee may challenge the denial of coverage of, or payment for, such assistance.

Effective Date

- Contracts entered into on and after October 1, 1997.

"Section 1932(b)(5) Demonstration of Adequate Capacity and Services"

Provision

- Each managed care organization must provide the Secretary and the State with adequate assurances that the organization has the capacity to serve the expected enrollment in the service area, including assurances that the organization offers an appropriate range of services and access to preventive and primary care services, and maintains a sufficient number, mix, and geographic distribution of providers of services.

Effective Date

- Contracts entered into on and after October 1, 1997.

"Section 1932(b)(6) Protecting Enrollees Against Liability for Payment"

Provision

- Enrollees may not be held liable for payments to providers or entities that are not made by the State in the event of entity insolvency. The Secretary may require subcontractors to comply with the same rules as if the managed care entity were providing services directly.

Effective Date

- Contracts entered into on and after October 1, 1997.

"Section 1932(b)(7) Antidiscrimination"

Provision

- A managed care organization may not discriminate with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable State law, solely on the basis of such license or certification.

Effective Date

- Contracts entered into on and after October 1, 1997.

Quality Assurance Standards (Section 4705)

Section 4705 further amends the new section 1932, adding the following provisions related to quality assurance in managed care:

+ Quality Assessment and Improvement Strategy
+ Increased FFP for External Quality Review Organizations
+ Studies and Reports

"Section 1932(c)(1) Quality Assessment and Improvement Strategy"

Provision

o The State must develop and implement a quality assessment and improvement strategy, to include: (1) Standards for access to care so that covered services are available within reasonable time-frames and in a manner that ensures continuity of care, adequate primary care, and specialized services capacity; (2) Grievance procedures and marketing and information standards; (3) Procedures for monitoring the quality and appropriateness of care to enrollees that includes requirements for provision of quality assurance data to the State using the data and information set under Medicare.

Effective Date

o Contracts entered into on and after January 1, 1999.

"Section 1932(c)(2) External Independent Review of Managed Care Activities"

Provision

o Each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible. In the case of a Medicaid managed care organization that is accredited by a private independent entity, the external review activities must not duplicate review activities conducted as part of the accreditation process. At the option of the State, if an organization is engaged in Medicare and has been under a Medicaid contract for two years, it is exempt from an annual external review. The Secretary and the National Governor's Association must contract with an independent quality review organization such as NCQA to develop protocols to be used in external independent reviews conducted on and after January 1, 1999. Federal Financial Participation funds will account for 75 percent of the sums expended attributable to the performance of independent external reviews (sec. 1903(a)(3)(C)).

Effective Date

- Contracts entered into or renewed on or after October 1, 1997.

Studies and Reports (Section 4705(c))

Provisions

- The Comptroller General must conduct a study and analysis of the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector or under the Medicare program. The study will determine if such standards include consideration of the accessibility and quality of the health care services delivered to low-income individuals; and the appropriateness of applying such standards to Medicaid managed care organizations under section 1932(c). The Comptroller General must report the findings to the House Commerce Committee and the Senate Finance Committee.

- The Secretary of the Department of Health and Human Services, in consultation with the States, the National Academy of State Health Policy, and others must conduct a study concerning safeguards that may be needed to ensure that the health care needs of individuals with special health care needs who are enrolled in Medicaid managed care are adequately met. The Secretary must report the findings to the House Commerce Committee and the Senate Finance Committee within two years of enactment.

Effective Date

- Contracts entered into or renewed on or after October 1, 1997.

Solvency Standards (Section 4706)

Provision

- The managed care organization must meet solvency standards established by the State for private health maintenance organizations. This requirement does not apply if the organization is not responsible for the provision of inpatient hospital services and physician services, is a public entity, its solvency is guaranteed by the State, or is made up of one or more Federally-qualified health centers (FQHCs) and meets State solvency standards for FQHCs.

Effective Date

- Contracts entered into or renewed on or after October 1, 1998.

Protections Against Fraud and Abuse (Section 4707)

Section 4707 of the Balanced Budget Act of 1997 includes the following provisions on fraud and abuse in managed care:

+ Prohibiting Affiliations with Individuals Debarred by Federal Agencies
+ Restrictions on Marketing
+ State Conflict of Interest Safeguards in Medicaid Risk Contracting
+ Use of Unique Physician Identifier for Participating Physicians
+ Sanctions for Noncompliance
+ Limitation on Availability of FFP for Use of Enrollment Brokers

These provisions are described below.

"Section 1932(d)(1) Prohibiting Affiliations with Individuals Debarred by Federal Agencies"

Provision

o A managed care entity may not knowingly have a director, officer, partner, or person with more than 5% of the entity's equity, or have an employment, consulting, or other agreement with such a person for the provision of items and services that are significant and material to the entity's contractual obligation with the State who has been debarred or suspended by the Federal government.

Effective Date

o Contracts entered into or renewed on or after October 1, 1997.

"Section 1932(d)(2) Restrictions on Marketing"

Provision

o A managed care organization may not distribute marketing materials without prior State approval and they cannot contain false or misleading information. In the process of reviewing marketing materials, the State must consult with a medical care advisory committee. Each plan must market to its entire service area. No tie-ins with other insurance products are permitted. Each managed care entity must comply with procedures the Secretary prescribes in order to ensure that an individual is provided accurate oral and written information sufficient to make an informed enrollment choice. No cold calls, either door-to-door or telephonic, are permitted.

Effective Date

o Contracts entered into or renewed on or after October 1, 1997.

"Section 1932(d)(3) State Conflict-of-Interest Safeguards in Medicaid Risk Contracting"

Provision

- The State must have conflict-of-interest safeguards for officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in (a)(4)(C)(ii) that are at least as effective as the Federal safeguards provided under section 27 of the Office of the Federal Procurement Policy Act that apply to procurement officials with comparable responsibilities.

Effective Date

- Contracts entered into or renewed on or after October 1, 1997.

"Section 1932(d)(4) Use of Unique Physician Identifier for Participating Physicians"

Provision

- Each managed care organization must require its physicians who provide Medicaid services to have a unique identifier in accordance with the system established under section 1173(b).

Effective Date

- Contracts entered into or renewed on or after October 1, 1997.

"Section 1932(e) Sanctions for Noncompliance"

Provision

- A State may not enter into or renew a contract under 1903(m) unless it has established intermediate sanctions, which may include civil money penalties in the amounts listed in parenthesis, or other remedies discussed below. The State may impose sanctions if the organization:
  - + fails substantially to provide medically necessary items and services that are required under law or under contract (not more than $25,000);
  - + imposes excess premiums and charges (double the excess amount charged);
  - + acts to discriminate among enrollees (not more than $100,000); or
  - + misrepresents or falsifies information (not more than $100,000).

+ violates marketing guidelines.

o The State also could:

+ appoint temporary management to oversee the entity if a plan engages in continued egregious behavior or there is a substantial risk to the health of enrollees;

+ permit individuals to disenroll without cause;

+ suspend default enrollment; or

+ suspend payment for new enrollees.

o In the case of a plan that repeatedly violates section 1903(m), the State must appoint temporary management and permit enrollees to disenroll without cause.

o A State may not terminate a contract with a managed care entity unless the entity is provided a hearing. The State may notify enrollees of the hearing and allow them to disenroll without cause.

o The provision permitting sanctions for failure to provide medically necessary services does not apply to abortion services, except that a State may impose sanctions on any managed care organization that has a contract to provide abortion services and does not provide such services under the contract.

Effective Date

o Contracts entered into or renewed on or after April 1, 1998.

"Section 1903(b) Limitation on Availability of FFP For Use of Enrollment Brokers"

Provision

o State expenditures for enrollment brokers are considered to be necessary for the proper administration of the State plan, but only if the broker is independent of any managed care entity or health care provider that provides services in the same State in which the broker is conducting enrollment activities. No owner, employee, or person who has a contract with the broker may have any financial interest in such an entity or provider, nor may the individual have been debarred by any Federal agency or subject to civil penalties under the Act.

Effective Date

o Contracts entered into or renewed on or after April 1, 1997.

Improved Administration (Section 4808)

Section 4808 improves managed care administration with the following provisions:

+ Change in Threshold Amount for Contracts Requiring Secretary's Prior Approval
+ Permitting Same Copayment in Health Maintenance Organizations as in Fee-For-Service
+ Assuring Timeliness of Provider Payments

These are described below.

Change in Threshold Amount for Contracts Requiring Secretary's Prior Approval (Section 4708(a))

Provision

o The threshold for the requirement that State contracts be approved by the Secretary is raised from $100,000 to $1,000,000.

Effective Date

o Contracts entered into or renewed on or after October 1, 1997.

Permitting Same Copayments in Health Maintenance Organizations as in Fee-For-Service (Section 4708(b))

Provision

o Copayments in managed care organizations will now be permitted in the same manner as they are permitted in a fee-for-service arrangement.

Effective Date

o Applies to contracts entered into or renewed on or after October 1, 1997.

Assuring Timeliness of Provider Payments (section 1932(f))

Provision

o A managed care organization must pay health care providers on a timely basis consistent with the claims payment procedures described in section 1902(a)(37)(A), unless the

health care provider and the organization agree to an alternative payment schedule.

Effective Date

o Contracts entered into or renewed on or after October 1, 1997.

6-Month Guaranteed Eligibility for All Individuals Enrolled in Managed Care (Section 4709)

Provision

o The State may provide up to six months minimum enrollment that covers all managed care entities.

Effective Date

o October 1, 1997.

SUBTITLE H--MEDICAID

Chapter 2--Flexibility in Payment of Providers

Flexibility in Payment Methods for Hospital, Nursing Facility, ICF/MR, and Home Health Services (Section 4711)

Provision

o Repeals the Boren amendment. A public notice process is established for setting rates for hospitals, nursing facilities, and ICFs/MR. In the case of hospitals, States would be required to take into account those that serve a disproportionate number of low-income patients when setting their payment rates to such hospitals. A State must give reasonable opportunity to affected providers and to beneficiaries to review and comment on any changes that the State proposes.

The Secretary must conduct a study of the new rate-setting methods and their effect on beneficiary access to care and the quality of services. Findings and recommendations are to be included in a report to Congress.

Effective Date

o Items and services furnished on or after October 1, 1997. The report must be done no later than four years after enactment.

Payment for Center and Clinic Services (Section 4712)

Provisions

- Phases out cost-based reimbursement for FQHCs and RHCs. Payment will be 95% for services furnished in FY 2000, 90% in FY 2001, 85% in FY 2002 and 70% in FY 2003. There are two provisions regarding managed care payments to these centers. The first provides that the State make up the difference between what the managed care organization (MCO) pays and the phased-down percent of cost-based reimbursement. The second provision provides for a transitional payment for services provided to FQHCs and RHCs by managed care organizations so that the payment MCOs provide to FQHCs and RHCs is not less than the level and amount of payment the MCOs would make for the services if they were furnished by another provider. Both provisions are repealed for services furnished on or after October 1, 2003.

- Clarifies the definition of FQHC to provide that "look-alike facilities must comply with requirements relating to ownership and control by other entities.

Effective Date

- Services furnished on or after October 1, 1997.

Elimination of Obstetrical and Pediatric Payment Rate Requirements (Section 4713)

Provision

- Repeals section 1926 of prior law, which contained requirements that States assure adequate Medicaid payment levels for obstetrical and pediatric services and provide annual reports on their payment rates for these services.

Effective Date

- Services furnished on or after October 1, 1997.

Medicaid Payment Rates for Certain Medicare Cost-Sharing (Section 4714)

Provision

- Permits States to limit the payments that they must make for Medicare deductibles and coinsurance for qualified Medicare beneficiaries (QMBs) to amounts that, when added to the amount paid by Medicare, equal the amounts that the State pays for the same service when provided to Medicaid beneficiaries who are not entitled Medicare. Providers under both Medicaid and Medicare must consider these payment amounts as payment in full.

Beneficiaries are not liable for any additional charges billed by providers or by a managed care entity. Providers or managed care entities that charge beneficiaries excess amounts are subject to sanctions.

Effective Date

- Upon enactment. The provisions are also effective retroactively in the case of payments for items or services furnished before enactment if they are the subject of a lawsuit pending on, or initiated after, the date of enactment.

Treatment of Veterans' Pensions Under Medicaid (Section 4715)

Provision

- The provision affects the disposition of payments made by VA to veterans who reside in certain State veterans' homes that also participate in Medicaid as nursing homes. VA payments in excess of $90 per month to residents of these facilities, including payments for aide and attendant care and for unreimbursed medical expenses, must be counted as income available to be applied to the cost of nursing home care. The provision applies only to veterans without spouses or children, as well as to surviving, childless spouses of veterans.

Effective Date

- October 1, 1997.

SUBTITLE H--MEDICAID

Chapter 3 -- Federal Payments to States

Reforming Disproportionate Share Payments Under State Medicaid Programs (Section 4721)

Provisions

- Allotments--States' DSH allotments are changed. New allotments are provided each year for FYs 1998-2002. After FY 2003, the allotments increase by the Consumer Price Index. This allotment must be greater than, or equal to, the DSH allotment for the previous year, but the DSH allotment may not be increased to the extent that it would exceed 12 percent of medical assistance expenditures.

- Limitations on Payments to IMDs--This provision mandates that aggregate DSH

payments to IMDs not exceed the lesser of:

+ A State's Federal share of total mental health DSH expenditures for 1995; or

+ The amount equal to the "applicable percentage" of the 1995 Federal share of DSH spending applicable to the 1995 DSH allotment as of January 1, 1997.

The applicable percentage, for fiscal years 1998, 1999, and 2000, is the Federal share of mental health DSH payments as a proportion of the Federal share of the total DSH spending amount in 1995. The applicable percentage for fiscal year 2001 is 50; 40% for 2002; and 33% for each succeeding year.

o Targeted Payments--Provides targeted payments for hospitals serving high numbers of uninsured and Medicaid patients. States must develop methodologies to identify and make payments to disproportionate share hospitals--including children's hospitals--on the basis on the proportion of low-income and Medicaid patients served by such hospitals. This methodology must be submitted to the Secretary by October 1, 1998. States are responsible for providing an annual report to the Secretary describing the DSH payments to each hospital that receives DSH payments.

o After October 1, 1997, DSH payments must be made to hospitals and not to managed care entities. This provision does not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.

o Permits California to have facility-specific limits of 175% of costs for two years through, October, 1999.

Effective Date

o October 1, 1997.

Treatment of State Taxes Imposed on Certain Hospitals (Section 4722)

Provision

o Hospitals described in section 501(c)(3) of the Internal Revenue Code that do not receive Medicaid or Medicare payments--intended to capture Shriners' Hospitals--are exempt from broad-based health care-related taxes. A State's FFP will be reduced by the amount of any health care-related tax imposed on an aforementioned hospital.

o Health care related taxes, fees, assessments (as defined in Section 1903(w)(3)(A)) which were collected by New York before June 1, 1997 and not acted on by the Secretary as of July 23, 1997, are deemed permissible, even if these taxes did not meet the test of the

broad-based standard and uniformity provisions in law. This provision applies to both taxes for which New York has applied for a waiver and those for which they have not applied for a waiver.

Effective Date

- The exemption from broad-based taxes applies to taxes imposed before, on, or after October 1, 1997. The penalty to States applies to taxes imposed on or after that date.

- The provision relating to New York is the subject of a Presidential line-item veto. As enacted, it would apply to taxes collected before June 1, 1997, effective upon enactment.

Additional Funding for State Emergency Health Services Furnished to Undocumented Aliens (Section 4723)

Provision

- Establishes a new entitlement to States that provides $25 million per year for each of four consecutive fiscal years (1998 - 2001) to the 12 States that demonstrate serving the highest number of undocumented aliens. The Secretary must pay the allotments to each State (or political subdivision) for emergency health services furnished to undocumented aliens. The term "State" includes the District of Colombia.

Effective Date

- Upon enactment.

Elimination of Waste, Fraud, and Abuse (Section 4724)

Provision

- (a) Ban on Spending for Nonhealth Related Items--An explicit ban is imposed on the use of Federal Medicaid matching funds for non-health related items such as bridges, roads, stadiums, or other items not covered by a State's Medicaid plan.

Effective Date

- Upon enactment.

Provision

- (b) Surety Bond Requirement for Home Health Agencies--Prohibits Federal Medicaid matching funds for home health services unless the home health agency or organization

provides the State Medicaid agency a surety bond in a form specified by the Secretary for Medicare home health providers. The amount of the surety bond must be no less than $50,000, or an amount comparable to that specified by the Secretary for Medicare.

Effective Date

- For home health services furnished on or after January 1, 1998.

Provision

- (c) Conflict of Interest Safeguards--Safeguards against conflict of interest that apply under current law to employees of agencies of local or State government that administer Medicaid are extended to independent contractors. In addition, State Medicaid conflict of interest safeguards must be at least as stringent as Federal procurement safeguards under the Office of Federal Procurement Policy Act.

Effective Date

- January 1, 1998.

Provision

- (d) Authority to Refuse to Enter Into Medicaid Agreements with Individuals or Entities Convicted of Felonies--Permits States to bar a provider convicted of a felony under State or Federal law from participating as a Medicaid provider if the State determines that the offense is inconsistent with the best interests of Medicaid beneficiaries.

Effective Date

- Upon enactment.

Provision

- (e) Monitoring Payments for Dual Eligibles--HCFA must develop mechanisms to monitor Medicaid payments made on behalf of persons eligible for both Medicaid and Medicare, and to prevent inappropriate payments.

Effective Date

- Upon enactment.

Provision

- (f) Beneficiary and Program Protections Against Waste, Fraud, and Abuse--Requires States to establish a mechanism to receive reports from beneficiaries and compile data on alleged instances of waste, fraud, and abuse in the Medicaid program.

Effective Date

- Effective upon enactment; mechanism to be developed not later than one year after enactment.

Provision

- (g) Disclosure of Information and Surety Bond Requirement for Suppliers of Durable Medical Equipment--Prohibits States from issuing provider numbers to DME suppliers unless the supplier complies with certain requirements. The supplier must provide the State with information about the supplier's or any subcontractor's ownership (direct or indirect) or control interest. Also, the supplier must have a surety bond as specified for Medicare and in an amount that is not less than $50,000 or another amount permitted by the Secretary.

Effective Date

- For Medicaid services consisting of durable medical equipment furnished on or after January 1, 1998.

Increased FMAPs (Section 4725)

Provisions

- Raises Alaska's FMAP from 50% in FY 1997 to 59.8% with respect to all items and services under Medicaid, under a State child health plan, payments made on a capitation or other risk-basis, and payments under DSH during FYs 1998, 1999 and 2000.

- The District of Columbia's FMAP is permanently increased from 50% to 70% for all items and services furnished after October 1, 1997.

Effective Date

- For items and services provided after October 1, 1997.

Increase in Payment Limitation for Territories (Section 4726)

Provision

- Raises Medicaid caps to the following amounts for FY 1998:

Puerto Rico	$30 million
Virgin Islands	$750,000
Guam	$750,000
Northern Mariana Islands	$500,000
American Samoa	$500,000

For FY 1999 and thereafter, the extra funding for territories will be the amount provided in FY 1998 increased by the medical care component of the Consumer Price Index.

Effective Date

- For items and services furnished on or after October 1, 1997.

SUBTITLE H--MEDICAID

Chapter 4--Eligibility

State Option of Continuous Eligibility for 12 Months; Clarification of State Option to Cover Children (Section 4731)

Provision

- Permits States to provide individuals under age 19 with up to 12 months of continuous eligibility after they are determined eligible for Medicaid.

- Clarifies that States are permitted to cover all children under age 19 up to 100 percent of poverty for the applicable family size.

Effective Date

- For Items and services furnished on or after October 1, 1997.

Payment of Part B Premiums (Section 4732)

Provision

- New Medicaid Program--Requires States to pay for Medicare Part B premium assistance for new groups of low-income Medicare beneficiaries as described below.

- Eligibility and Benefits--Raises the income eligibility level for the full Part B premium

from the current level of 120 percent of poverty to 135 percent of poverty. Medicare beneficiaries with incomes between 135 and 175 percent of poverty and with low assets are eligible for Medicaid assistance consisting only of the increase in the Part B premium attributable to the shift of Medicare home health coverage into Part B. (The phase-in of these costs, described in Section 4611(e)(3) of the Balanced Budget Act, will be completed in 2004.)

- o Selection of Recipients from Among Eligibles--States must permit all who qualify to apply. However, States must limit the number selected in a calendar year so that the aggregate cost for the number served is estimated to equal the State's allocation in that year. Selection by States is on a first-come, first-served basis. Persons selected to receive assistance in a calendar year are entitled to receive assistance for the remainder of the year, but not beyond, if they continue to qualify, and if unspent amounts remain of the State's funding allocation for this program. In selecting persons who will receive assistance in years after 1998, States must give preference to persons who received assistance in the last month of the previous year.

- o Financing--A total of $1.5 billion is allocated over five years ($200 million in 1998, $250 million in 1999, $300 million in 2000, $350 million in 2001, and $400 million in 2002). A State's allocation is based on the Secretary's estimate of the sum of twice the number of Medicare beneficiaries between 120 and 135 percent of poverty, plus the number of such beneficiaries between 135 and 175 percent of poverty, relative to the sum for all States.

  Costs of this program are financed through funds transferred from the Federal Supplementary Medical Insurance Trust Fund. The Federal matching rate is 100 percent for spending up to a State's allocation, and 0 percent for spending in excess of the allocation amount.

Effective Date

- o For premiums payable with respect to months beginning January, 1998 through December, 2002.

State Option to Permit Workers with Disabilities to Buy into Medicaid (Section 4733)

Provision

- o Permits States to allow certain disabled SSI beneficiaries who would lose eligibility because their earnings exceed the allowable limit to buy into Medicaid. Eligibility is limited to SSI beneficiaries who are in families whose income is less than 250 percent of the official poverty line for the applicable family size. States will set the premiums based on an income-related sliding scale.

Effective Date

- Upon enactment.

Penalty for Fraudulent Eligibility (Section 4734)

Provision

- A person is subject to criminal penalties if, for a fee, the person knowingly and willfully counsels or assists an individual to dispose of assets for the purpose of appearing to be poor enough to qualify for Medicaid, and if, as a consequence of asset disposal, the individual has been denied Medicaid coverage of certain long-term care benefits.

Effective Date

- Upon enactment.

Treatment of Certain Settlement Payments (Section 4735)

Provision

- Payments received by certain HIV-infected persons as a result of a settlement against manufacturers of blood products are not counted as either income or resources in determining the recipient's eligibility for, or the amount of, benefits under Medicaid.

Effective Date

- Upon enactment.

SUBTITLE H--MEDICAID

Chapter 5--Benefits

Elimination of Requirement to Pay for Private Insurance (Section 4741)

Provision

- The current requirements that (1) States identify and enroll Medicaid eligibles in private insurance when cost-effective, and (2) States require such individuals to enroll in a private plan as a condition of Medicaid eligibility, are converted to a State option.

Effective Date

- Upon enactment.

Physician Qualification Requirements (Section 4742)

Provision

- The current requirement regarding minimum qualifications for a physician who furnishes Medicaid services to a child under age 21 or to a pregnant woman, is repealed.

Effective Date

- Upon enactment.

Elimination of Requirement of Prior Institutionalization with Respect to Habilitation Services Furnished Under a Waiver for Home or Community-Based Services (Section 4743)

Provision

- The home and community-based waiver program (section 1915(c)(5)) is amended by eliminating the requirement that individuals be discharged from a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR) in order to receive habilitation services under a home and community-based services waiver.

Effective Date

- For services furnished on or after October 1, 1997.

Study and Report on EPSDT Benefit (Section 4744)

Provisions

- The Secretary of HHS, in consultation with Governors, directors of State Medicaid programs, the American Academy of Actuaries, and representatives of appropriate provider and beneficiary organizations, must conduct a study of the EPSDT services which State Medicaid programs are required to provide by section 1905(r) of existing law.

- The study must include an examination of the actuarial value of the EPSDT services provided under the Medicaid program, and the actuarial value attributable to the non-screening (i.e., treatment) portion of those services.

Effective Date

- The results of the study must be submitted to the Congress not later than 12 months after the date of enactment.

SUBTITLE H--MEDICAID

Chapter 6--Administration and Miscellaneous

Elimination of Duplicative Inspection of Care Requirements for ICFs/MR and Mental Hospitals (Section 4751)

Provision

- The requirement for periodic inspections of care (IOC) for each Medicaid beneficiary receiving services in an ICF/MR is repealed. These inspections were considered duplicative in that they have been subsumed by a new outcome-oriented survey process for ICFs/MR.

Effective Date

- Upon enactment.

Alternative Sanctions for Noncompliant ICFs/MR (Section 4752)

Provision

- Creates an alternative for States to address the problem of ICFs/MR that are out of compliance with the survey and certification requirements. States may use the same alternative remedies to deter noncompliance and correct deficiencies for ICFs/MR as they may use for nursing facilities.

Effective Date

- Upon enactment.

Modification of MMIS Requirements (Section 4753)

Provision

- Current outdated Medicaid management information requirements are replaced. States must operate systems that:
  - are adequate to efficient, economical, and effective administration;

+ are compatible with Medicare claims processing and information retrieval systems;

+ are capable of providing accurate and timely data;

+ comply with part C of title XI (administrative simplification requirements enacted in subtitle F of the Health Insurance Portability and Accountability Act of 1996);

+ can receive provider claims in standardized formats;

+ for claims filed on or after January 1, 1999, can electronically transmit data in a format consistent with the Medicaid Statistical Information System (MSIS).

State systems for pursuing third party payments must be integrated with the new MMIS systems.

Effective Date

o January 1, 1998.

Facilitating Imposition of State Alternative Remedies on Noncompliant Nursing Facilities (Section 4754)

Provision

o Eliminates the current requirement that States reimburse HCFA for any payments to non-compliant nursing facilities that do not follow the corrective action plan. This provision permits States to promote compliance through remedies other than termination of the facility without a repayment requirement.

Effective Date

o Upon enactment.

Removal of Name from Nurse Aide Registry (Section 4755)

Provision

o Authorizes Medicare and Medicaid to establish a procedure for a nurse aide to petition to have her/his name removed from the national registry which documents incidents of abuse, neglect, and misappropriation of property. A small exception is provided under which a name could be removed only in cases where the employment and personal history of the nurse aide does not reflect a pattern of abusive or neglectful behavior, and

that the neglect involved was a singular occurrence.

Effective Date

- Effective upon enactment. Retroactive review is available back to January 1, 1995.

Medically Accepted Indication (Section 4756)

Provision

- *DRUGDEX Information System* becomes part of the compendia under section 1927(g)(1)(B)(I) from which the State drug use review programs assess predetermined drug data standards.

Effective Date

- Upon enactment.

Continuation of State-Wide Section 1115 Medicaid Waivers (Section 4757)

Provision

- During the 6-month period ending one year before a section 1115 waiver would expire, a State may submit a request for an extension of up to 3 years. The Secretary must review requests and can approve or disapprove waiver extensions. If the Secretary fails to respond to the State's request within 6 months, the request is automatically granted.

  For those section 1115 waivers that are granted an extension, States must submit a final report one year after the waiver would have previously expired. The Secretary must release an evaluation of each project not later than one year after receipt of the final report.

  Section 1115 waiver extensions must be on the same terms/conditions that applied to the waiver before its extension, including access to services, budget neutrality, data and reporting requirements, and special population protections. If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary will take such steps as may be necessary to ensure that, in the extension of the project, such conditions continue to be met.

Effective Date

- For demonstration projects initially approved before, on, or after October 1, 1997.

Extension of Moratorium (Section 4758)

Provision

- Medicaid law generally prohibits payment for services provided by an institution for mental diseases (IMDs) for beneficiaries between the ages of 21 and 65. (An IMD is an institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care for persons with mental diseases.) Previous legislation imposed a moratorium on determining two facilities in Michigan (Kent Community Hospital Complex and Saginaw Community Hospital) to be IMDs. This moratorium is extended for these two facilities from December 31, 1995 through December 31, 2002.

Effective Date

- Upon enactment.

Extension of Effective Date for State Law Amendment (Section 4759)

Provision

- If a State must enact State legislation to meet any of the requirements imposed by the new Medicaid provisions of this law, the State will not be considered out of compliance solely because of failure to meet the new requirements until the end of the first regular State legislative session that begins after enactment of this law.

Effective Date

- The State has until the first day of the first calendar quarter after the end of the first regular State legislative session that begins after enactment of this law to enact any State laws necessary. In a State with a 2-year legislative session, each year of the session is considered a separate regular session of the State legislature for this purpose.

SUBTITLE I--PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Coverage of PACE Under the Medicare Program (Section 4801)

Section 4801 outlines the PACE provisions for the Medicare program. Section 4802 generally contains parallel language for the PACE protocol for Medicaid.

Receipt of Benefits Through Enrollment in PACE Program; Definitions for PACE

Program Related Terms (Section 4801(a))

Provisions

- Adds section 1894 to the Medicare statute establishing PACE. A PACE program is defined as a program of all-inclusive care for the elderly whose services are delivered by a qualified PACE provider--a provider of comprehensive health care benefits that is a public or private, non-profit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986.

- Individuals may enroll in the PACE program as long as they do so in accordance with the regulations, receive benefits solely through the PACE program, and the PACE provider receives payment in accordance with the PACE program agreement. Individuals may be dually eligible for both Medicare and Medicaid, for Medicaid-only, and, in come cases, for Medicare-only.

- PACE-program eligible individuals are 55 years of age or older; require the nursing facility level of care; reside in the service area of the PACE program; and meet other eligibility conditions imposed under the PACE program agreement.

Scope of Benefits; Beneficiary Safeguards (Section 4801(b))

Provisions

- Regardless of the source of payment, PACE providers must make available all items and services covered under both Titles XVIII and XIX without any limitations on amount, duration or scope; and without application of deductibles, copayments, or other cost sharing.

- Enrollees must have access to benefits 24 hours per day, every day of the year, and services must be provided through a comprehensive, multi disciplinary system which integrates acute and long-term care services.

- Providers must arrange for the delivery of all covered items and services not provided directly by the entity itself.

- The PACE program agreement must include a written plan of quality assurance and improvement and a set of written safeguards (including a patient bill of rights and grievance and appeals procedures).

Eligibility Determinations (Section 4801(c))

Provisions

- Individuals may be deemed to continue to be eligible for PACE if they could reasonably be expected to re-qualify for a nursing home level of care within the following 6 months, if PACE services were denied.

- Eligibility determinations must be made in accordance with the PACE program agreement and may be made by the State Medicaid agency.

- The health status of individuals must be comparable to that of other individuals who have participated in PACE demonstration waiver programs. Health status will be determined by indicators such as medical diagnosis, activities of daily living (ADLs), and cognitive impairment.

- PACE-eligible individuals are subject to annual eligibility recertifications in order to ensure that they are being appropriately served in a PACE setting. This includes an exception in cases where the severity of a chronic condition or degree of impairment warrants no reasonable expectation of improvement or significant change in condition.

- Individuals served by PACE may voluntarily disenroll from the program at any time. The PACE program may not disenroll individuals except in cases of nonpayment of premiums (if applicable) or in cases where the individual is engaging in disruptive or threatening behavior. Non-voluntary disenrollment is subject to review by the Secretary or the State agency.

- All new PACE programs are subject to a trial period that lasts for the first 3 contract years of the PACE program agreement. Years that an entities previously operated under a PACE demonstration count toward this requirement.

Payments to PACE Providers on a Capitated Basis (Section 4801(d))

Provisions

- Requires the Secretary to make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under a PACE agreement. Payment must be made in the same manner and from the same source as payments made to a Medicare+Choice organization.

- The capitation amount is the yearly amount specified in the PACE program agreement. The payments must be adjusted to take into account the comparative frailty of PACE enrollees and be computed in a manner so that the total payment level for all PACE-eligible individuals in a program is less than the projected payment for a comparable non-PACE population.

PACE Program Agreement (Section 4801(e))

Provisions

- Limits the number of PACE program agreements to 40 in the first year after enactment, and 20 sites each year thereafter. Certain private, for-profit providers operating under the new demonstration authority (see subsection (h)) will not be counted toward this limit.

- The agreement must designate a service area for the PACE program, and contain terms and conditions agreed to by all of the relevant parties. The Secretary, in consultation with the State, may exclude from designation an area that is already covered by another PACE program agreement to avoid unnecessary duplication of services and impairment of financial viability.

- PACE program agreements must include data collection procedures; PACE providers, the Secretary, and the State must also develop outcome measures. During the initial 3-year trial period, the Secretary will conduct a comprehensive annual review of a PACE provider to assure compliance with the requirements of this section and the regulations.

- The Secretary may terminate PACE provider agreements in cases where the annual reviews identify significant deficiencies in the quality of care or where the provider is substantially out of compliance with the conditions of the PACE program and fails to initiate a corrective action plan.

Regulations (Section 4801(f))

Provisions

- Within one year of enactment, requires the Secretary to issue regulations to carry out the elements of the PACE protocol, while allowing for flexibility in adapting the PACE protocol to meet needs of specific organizations (such as sites in rural areas), as long as the flexibility is in keeping with the essential elements of the PACE protocol.

- The regulations may include special beneficiary protections and program integrity provisions in the same manner as those applied to Medicare+Choice and Medicaid managed care organizations.

Waivers of Requirements (Section 4801(g))

Provision

- This provision lists all of the applicable sections of Title XVIII that are waived in order to facilitate the effective administration of PACE within the Medicare program.

Demonstration for For-Profit Entities (Section 4801(h))

Provisions

- Requires the Secretary (in close consultation with the State administering agency) to grant waivers from the requirement that PACE sites be public or private non-profit entities. This provision allows up to 10 for-profit PACE demonstrations, but the providers must operate under the same terms and conditions as those of the regular PACE program.

- At the end of the demonstration period, the Secretary will conduct a study and report on the effectiveness and quality of the for-profit demonstrations, at which point these sites will have the opportunity to become permanent PACE providers unless the results of the study indicate that the major elements of cost effectiveness and quality of care are not being met under the demonstrations.

Establishment of PACE Program as Medicaid State Option (Section 4802)

Section 4801 outlines the PACE provisions for the Medicare program. Section 4802 generally contains parallel language for the PACE protocol for Medicaid.

Program of All-Inclusive Care For the Elderly (PACE) (Section 4802(a))

Provisions

- Adds section 1934, under which States may elect to provide PACE program services to individuals who are Medicaid-eligible and are enrolled in a PACE program. Individuals need not be enrolled in Medicare to be eligible under section 1934.

- The rest of the provisions parallel the Medicare language in section 4801(a).

Scope of Benefits; Beneficiary Safeguards (Section 4802(b))

Provision

- Parallels Medicare language in section 4801(b).

Eligibility Determinations (Section 4802(c))

Provision

- Parallels Medicare language in section 4801(c).

Payments to PACE Providers on a Capitated Basis (Section 4802(d))

Provision

- Parallels Medicare language in section 4801(d).

PACE Program Agreement (Section 4802(e))

Provision

- Parallels Medicare language in section 4801(e).

Regulations (Section 4802(f))

Provision

- Parallels Medicare language in 4801(f).

Waivers of Requirements (Section 4802(g))

Provision

- Lists all applicable sections of Title XIX that are waived to facilitate the effective administration of PACE in Medicaid.

Demonstration Project for For-Profit Entities (Section 4802(h))

Provision

- Parallels Medicare language in section 4801(h).

Post-Eligibility Treatment of Income (Section 4802(i))

Provision

- States may provide for post-eligibility treatment of income for individuals enrolled in PACE in the same manner as States treat post-eligibility income for individuals receiving services under a home and community-based services waiver. That is, after an individual is determined to be Medicaid-eligible, a calculation of income is done to determine how much the individual is able to contribute toward his/her cost of care in an institution, in a home and community-based program, or in PACE.

Miscellaneous Provisions (Section 4802(j))

Provision

- Nothing in this section or in section 1894 prevents a PACE provider from entering into contracts with other governmental or non-governmental payers for the care of PACE program individuals who are not eligible for either Medicare or Medicaid.

Effective Date; Transition (Section 4803)

Provisions

- Requires the Secretary to promulgate regulations to facilitate the timely implementation of both sections 1894 and 1934--the PACE provisions. Regulations must be issued no later than one year after the date of enactment.

- Applications for participation in PACE under the new authority must be given timely consideration. HHS has 90 days to review and approve applications or request additional information. In the absence of an approval, disapproval, or request for additional information, the application will be deemed approved after 90 days.

- Special consideration will be given to those entities that are either currently operating under the demonstration authority or that submitted an application before May 1, 1997; or to those entities that have begun formal activities (such as contracting for feasibility studies) to indicate intent to become a PACE provider.

- States have the option to seek extension of the current demonstration authority for up to 3 years after the effective date of the regulations. If the State elects to continue operating PACE as a demonstration, it must do so under the same terms and conditions as the new PACE program.

Study and Report (Section 4804)

Provisions

- The Secretary must conduct a study of the quality and cost of providing PACE program services under the Medicare and Medicaid programs. This study will specifically compare the costs, quality, and access to services of for-profit entities operating under the demonstration authority of subsection (h). A report must be completed within 4 years after the date of enactment.

- The report will include an evaluation to determine whether enough people are enrolled in the for-profit demonstrations to make the study statistically valid; whether the population being served is less frail than the population served by the regular PACE program; whether access and quality of care is compromised under the for-profit demonstration; and whether the demonstration resulted in an increase in expenditures for the Medicare and Medicaid programs.

SUBTITLE J--STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Chapter 1--State Children's Health Insurance Program

Establishment of Program (Section 4901)

Provision

- Amends the Social Security Act to add a new title--Title XXI--State Children's Health Insurance Program. The provisions described below list the section numbers of the new title XXI.

"Section 2101 Purpose; State Child Health Plans"

Provision

- The purpose is to enable States to initiate and expand child health assistance to uninsured, low-income children. Such assistance should be provided primarily through either or both of two methods: (1) a program to obtain health insurance coverage that meets requirements in Section 2103 relating to the amount, duration, and scope of benefits; or (2) expanding eligibility for children under the State's Medicaid program. In order to be eligible for funds, States must submit to, and obtain approval from, the Secretary for a State Child Health Plan. This program is a capped entitlement for States.

Effective Date

- No State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2102 General Contents of State Child Health Plan; Eligibility; Outreach"

Provisions

- A State Child Health Plan must include general background on the extent children currently have coverage, current State efforts to obtain coverage, how the plan will be coordinated with other efforts, proposed delivery methods and methods to assure quality and access to covered services.

- A State Child Health Plan must describe standards and methods used to establish and continue eligibility and enrollment for targeted low-income children. The standards must cover lower income children within a category of covered children before higher income children and may not deny eligibility based on a preexisting condition. It also must

include a description of screening procedures to ensure that: only targeted low-income children receive assistance; Medicaid-eligible children are enrolled in Medicaid; this assistance does not substitute for group coverage; eligible Indian children receive assistance; and that there is coordination with other programs.

- o A State Child Health Plan must describe procedures for outreach to families of children likely to be eligible for assistance under the Plan or under other public or private coverage and to inform them of the availability of, and assist in, enrollment in these programs.

- o The Plan must describe coordination of the State program with other public and private insurance programs.

Effective Date

- o No State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2103 Coverage Requirements for Children's Health Insurance"

Provisions

- o Child Health Assistance (other than Medicaid), for a targeted low-income child must consist of any of the following:

  (1) Benchmark Coverage--Benefit plans must be equivalent to: the standard Blue Cross/Blue Shield Preferred Provider option offered under the Federal Employees Health Benefits Program (FEHBP); a health benefits plan that is offered and generally is available to State employees; and the HMO with the largest commercial enrollment in the State.

  (2) Benchmark-Equivalent Coverage--The coverage must include benefits in the following categories of basic services: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunizations. The coverage must have an aggregate actuarial value that is at least equivalent to one of the benchmark packages. The coverage also must be at least 75 percent of the actuarial value of the benchmark package value for each of the following additional services: prescription drugs, mental health, vision, and hearing services.

  (3) Existing Comprehensive State-Based Coverage--Coverage is defined as a program that: provides a range of benefits; is administered by the State and receives State funds; is offered in New York, Florida or Pennsylvania; was offered on the date of enactment of this title and, if modified, still includes a range of benefits and has an actuarial value

equal to, or greater than, either its value on August 5, 1997 or the value of one of the benchmark benefit packages.

(4) Secretary-Approved Coverage--Any other coverage that the Secretary determines provides appropriate coverage for targeted low-income children.

- A State Child Health Plan must include a description of the amount (if any) of cost-sharing and must be in accordance with a public schedule. Cost-sharing may be varied only in a manner that does not favor higher-income children over lower-income children. No cost-sharing is permitted for well-baby and well-child care, including age-appropriate immunizations. Cost-sharing for children in families below 150 percent of poverty must be consistent with Medicaid. Cost-sharing for children at 150 percent of poverty and above must be based on an income-related sliding scale and the annual aggregate for all children in a family cannot exceed 5 percent of the family's income.

- The State Child Health Plan may not impose pre-existing condition exclusions for covered benefits. States that provide for benefits through a group health plan or group health insurance coverage may permit pre-existing condition exclusions as allowed under the applicable section of the Employee Retirement Income Security Act (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA).

Effective Date

- No State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2104 Allotments"

Provisions

- Total allotments are: $4.275 billion for fiscal years 1998-2001; $3.15 billion for fiscal years 2002-2004; $4.05 billion for fiscal years 2005-2006; and $5 billion for fiscal year 2007. For each fiscal year, .25 percent of the total allotment must be allocated to the territories. In addition, $60 million of the total allotment is to be used for the special diabetes programs (see Sections 4921 and 4922).

- In fiscal years 1998-2000, each State with an approved Child Health Plan will receive an allotment based on the State's proportion of the total number of low-income (less than 200 percent of poverty) uninsured children multiplied by a geographic cost factor. For fiscal years 2001-2007, States will receive their allotment based on their proportion of a blended number of low-income uninsured and insured children multiplied by a geographic cost factor.

- For 2001, the blended number of low-income uninsured and insured children is equal to the sum of two factors: (1) 75 percent of the number of low-income uninsured children in the State; and (2) 25 percent of the number of low-income children in the State. For each succeeding year, the blended number of low-income uninsured and insured children is equal to the sum of two factors: (1) 50 percent of the number of low-income uninsured children in the State; and (2) 50 percent of the number of low-income children in the State. The geographic cost factor is based on annual wages in the health care industry. The number of children is calculated as a 3-year rolling average from the most recent March supplements of the Current Population Survey data sets.

- Each State will receive a minimum floor of $2 million. Amounts allotted to a State will be available for 3 years. Any amounts unused after 3 years will be redistributed to States that have fully spent their allotments.

- The territories will receive .25 percent of the total yearly allotments, to be divided among Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands in the following manner:

  + Puerto Rico receives 91.6 percent;
  + Guam receives 3.5 percent;
  + the Virgin Islands receive 2.6 percent;
  + American Samoa receives 1.2 percent; and
  + the Northern Mariana Islands receive 1.1 percent.

- The amount of a State's allotment will be reduced by the amount of Federal payments based on the State's expenditures for: (1) presumptive Medicaid eligibility for children under section 1920A; (2) Medicaid coverage described in section 1902(u)(2); and (3) Medicaid coverage for children under age 19, born before October 1, 1983, who would not have been eligible under the Medicaid State plan as of April 15, 1997, described in section 1902(u)(3).

Effective Date

- No State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2105 Payment to States"

Provisions

- The Secretary will make payments to States with approved Child Health Plans for child health assistance for targeted low-income children who meet the coverage requirements in Section 2103, after reducing for expenditures for presumptive eligibility and for

targeted low-income children under Medicaid. No more than 10 percent of a State's payments may be used for the total costs of: other child health assistance for targeted low-income children; health services initiatives; outreach; and administrative costs.

- The enhanced Federal medical assistance percentage (FMAP) for child health assistance provided under this title is equal to the current FMAP increased by 30 percent of the difference between 100 and the current FMAP. The enhanced FMAP may not exceed 85 percent. Federal funds, premiums, other cost-sharing, provider taxes and donations cannot be used for the State matching requirements.

- The Secretary may waive the 10 percent limitation for coverage meeting the benefits requirements of Section 2103 that she deems is a cost effective alternative and is provided through contracts with health centers receiving funds under section 330 of the Public Health Service Act or through disproportionate share hospitals. The Secretary also may allow payment to a State for the purchase of family coverage under a group health plan if the State establishes to her satisfaction that it is cost-effective and it would not substitute for existing coverage.

- No payment may be made for expenditures that would have been made under private coverage or under any Federally-operated/financed program other than an IHS-operated or -financed program.

- In addition, payments may not be used to pay for abortions or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion. Exceptions are provided for abortions that are necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. This would not prevent a State, locality or private person or private funds from purchasing coverage that includes abortions.

- States will not receive any payments for child health assistance if they adopt income and resource standards and methodologies for determining a child's eligibility for Medicaid that are more restrictive that those in effect on June 1, 1997. A State's allotment will be reduced by the amount by which the total of the State's children's health insurance expenditures in the preceding year is less than such expenditures in 1996. State children's health insurance expenditures are defined as the State share under this title, the State share under Medicaid attributable to an enhanced FMAP, and State expenditures for the "existing comprehensive State-based coverage."

Effective Date

- No State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2106 Process for Submission, Approval and Amendment of State Child Health Plans"

Provisions

- In order to receive funds under this title, a State must submit and obtain approval from the Secretary of its Child Health Plan. No funds are available prior to October 1, 1997. A State may submit an amendment to its Child Health Plan at any time. Any amendment that restricts or eliminates eligibility may not take effect unless the State certifies that it has provided prior public notice of the change and will not be effective for longer than 60 days unless it has been transmitted to the Secretary during the 60 day period. Other types of amendments will not remain in effect after the fiscal year (or, if later, the end of a 90 day period) unless the amendment has been transmitted to the Secretary.

- A State Child Health Plan or plan amendment is deemed approved unless the Secretary notifies the State in writing within 90 days after receiving the plan or amendment, that it is disapproved or that additional information is needed. The Secretary must provide a reasonable period for correction in the case of a disapproval.

- States must conduct the program in accordance with the approved plan and plan amendments. The Secretary must establish a process for enforcing the requirements under this title, including withholding funds in the case of substantial noncompliance. The Secretary must provide a reasonable period of correction before taking financial sanctions.

Effective Date

- No State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2107 Strategic Objectives and Performance Goals; Plan Administration"
Provisions

- A State Child Health Plan must include a description of strategic objectives, performance goals and performance measures for providing child health assistance to targeted low-income children and for maximizing health benefits coverage for other low-income children and children generally in the State. The Plan must describe how performance measures will be assessed through objective, independently verifiable means and compared against performance goals.

- A State Child Health Plan must include an assurance that the State will collect data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. It also must describe the State's plan for annual

assessments, reports, and evaluations and assure the Secretary access to records for audit purposes.

- A State Child Health Plan must include a description of its process for involving the public in the design and implementation of the plan, as well as for ongoing public involvement. There must also be a description of the budget for the Plan.

- Medicaid provisions relating to conflict of interest, limitations on payment, and limits on provider taxes and donations apply to this title. In addition, a number of fraud and abuse provisions of title XI of the Social Security Act apply to this title.

Effective Date

- No State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2108 Annual Reports; Evaluations"

Provisions

- The State must assess the operation of the State plan, including progress made in reducing the number of uncovered low-income children and report annually to the Secretary by January 1.

- By March 31, 2000, each State with an approved State Child Health Plan must submit to the Secretary an evaluation addressing: the State's effectiveness in increasing the number of children with creditable coverage; the effectiveness of other elements of the State's Plan, including characteristics of children served, quality, amount and level of assistance, service area, time limits, coverage and other sources of non-Federal funding; the effectiveness of other public and private programs in increasing the availability of affordable quality health coverage; the State's coordination between other public and private programs for children; an analysis of the changes and trends that affect affordable, accessible coverage for children; the State's plans for improving the availability of children's coverage; recommendations for improving the State's program; and other matters the State and Secretary deem appropriate.

- The Secretary must submit a report based on the State evaluations to Congress by December 31, 2001.

Effective Date

- No State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2109 Miscellaneous Provisions"

Provision

- Coverage other than Medicaid will be considered creditable coverage for purposes of HIPAA. ERISA will not be affected by this title.

"Section 2110 Definitions"

Provisions

- The following terms are defined: child health assistance; targeted low-income child; child; creditable health coverage; group health plan; health insurance coverage; low-income; poverty line; preexisting condition exclusion; State Child Health Plan; and uncovered child.

- The term "targeted low-income child" means a child who: meets the eligibility standards set by the State; resides in a family with income below the greater of the following: 200 percent of poverty or 50 percentage points above the Medicaid eligibility limit; and is not eligible for Medicaid or other health insurance coverage. An exception is that the term may include children covered under a health insurance coverage program in operation since before July 1, l997 that is offered by the State and receives no Federal funds. Children excluded are those who: are inmates of public institutions; patients in an institution for mental diseases (IMDs); and children whose families are eligible for the State employee benefits plan.

Effective Date

- No State is eligible for payments for child health assistance provided prior to October 1, 1997.

SUBTITLE J--STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Chapter 2--Expanded Coverage of Children Under Medicaid

Optional Use of State Child Health Assistance Funds for Enhanced Medicaid Match for Expanded Medicaid Eligibility (Section 4911)

Provisions

- States may elect to use child health assistance funds to expand Medicaid eligibility. In order to receive funds to expand Medicaid eligibility, States must meet two conditions:

(1) they must maintain their Medicaid eligibility at levels that are not more restrictive than those applied as of June 1, 1997; and (2) they must provide for reporting of information about expenditures relating to presumptive eligibility and to child health assistance provided to "optional targeted low-income children" under the expanded Medicaid program.

- States that elect to the use the child health assistance funds to expand Medicaid eligibility and meet the two conditions described above will be eligible to receive an enhanced Medicaid match for "optional targeted low-income children." The enhanced Medicaid match is the State's current FMAP increased by 30 percent of the difference between 100 and the current FMAP.

- The enhanced Medicaid match will apply to expenditures for "optional targeted low-income children." They are defined as targeted low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. It would not apply to expenditures for children below the poverty level who were born after September 30, 1983 as they age onto Medicaid under current law. If these expenditures exceed a State's allotment for the year (reduced by any expenditures for child health assistance paid to the State under the grant program), the State would receive only the regular FMAP, rather than an enhanced FMAP for the excess expenditures.

- The enhanced Medicaid match also will apply to expenditures for children born before September 30, 1983 who are under age 19 and who are not eligible under the State Medicaid plan as of April 15, 1997.

Effective Date

- For items and services furnished after October 1, 1997.

Medicaid Presumptive Eligibility for Low-Income Children (Section 4912)

Provisions

- States are permitted under their Medicaid program to make medical assistance available to children under 19 during a presumptive eligibility period. The period begins with a date that a qualified entity determines, using preliminary information, that the family income does not exceed the income eligibility level; and the period ends with the earlier of an eligibility determination or, if an application for eligibility has not been filed, on the last day of the month following the month the entity makes the preliminary determination.

- The term a "qualified entity" means an eligible provider under Medicaid or any entity authorized to determine eligibility for the Head Start program, the Child Care and Development Block Grant Act, or WIC. The Secretary may issue regulations further

limiting qualified entities.

- A qualified entity must notify the State agency of the determination within 5 working days and inform the parent or custodian of the child and that an application is required to be filed by the end of the following month.

Effective Date

- Upon enactment.

Continuation of Medicaid Eligibility for Disabled Children Who Lose SSI Benefits (Section 4913)

Provision

- States must continue Medicaid eligibility for disabled children who would have lost SSI benefits because of the change in the definition of childhood disability under the Personal Responsibility and Work Opportunity Act of 1996.

Effective Date

- July 1, 1997.

SUBTITLE J--STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Chapter 3--Diabetes Grant Programs

Special Diabetes Programs for Type I Diabetes (Section 4921)

Provision

- The Secretary must provide--directly or through grants--for research into the prevention and cure of Type I diabetes. Grants will be made available to children's hospitals, grantees under section 330 of the Public Health Service Act, and other Federally qualified health centers (FQHCs), State and local health departments and other public or non-profit private entities. For each of fiscal years 1998-2002, $30 million is transferred from title XXI for grants under this section.

Special Diabetes Programs for Indians (Section 4922)

Provision

- The Secretary must make grants for the prevention and treatment of diabetes (for individuals of all ages) for services provided through the Indian Health Service (IHS), through an Indian health program operated by a tribe or tribal organization funded by IHS, or through an urban Indian health program funded by IHS. For each of fiscal years 1998-2002, $30 million must be transferred from title XXI for grants under this section.

Report on Diabetes Grant Programs (Section 4923)

Provision

- The Secretary must conduct an evaluation of the diabetes grant programs in sections 4921 and 4922 and submit an interim report to Congress by January 1, 2000 and a final report by January 1, 2002.

TITLE V--WELFARE AND RELATED PROVISIONS

Subtitle D--Restricting Welfare and Public Benefits for Aliens

SSI Eligibility for Aliens Receiving SSI on August 22, 1996 and Disabled Aliens Lawfully Residing in the United States on August 22, 1996 (Section 5301)

Provisions

- Amends the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to provide continued SSI benefits for aliens who were lawfully residing in the United States and who were receiving SSI benefits on August 22, 1996 (the date of enactment of the welfare reform legislation), and who would otherwise qualify for SSI.

- Another exception is added to the ban on SSI benefits for legal immigrants: SSI (and Medicaid) is authorized for those who were residing in the U.S. on August 22, but who are disabled.

- The period is extended until September 30, 1998 for redetermining the eligibility of individuals who will lose their SSI due to failing to meet the definition of "qualified alien." SSI (and Medicaid) benefits for these "non-qualified" aliens will continue for one additional year if these aliens would otherwise qualify for SSI.

Effective Date

- Effective as if included in the enactment of the Personal Responsibility and Work Opportunity Act of 1996 (retroactive to August 22, 1996).

Extension of Eligibility Period for Refugees and Certain Other Qualified Aliens from 5 to 7 Years for SSI and Medicaid; Status of Cuban and Haitian Entrants (Section 5302)

Provisions

- The exemption from the 5-year ban on SSI and Medicaid benefits for refugees, asylees, individuals whose deportation has been withheld, and for Cuban/Haitian entrants, is extended to 7 years.

- Cuban/Haitian entrants are defined as "qualified aliens" for purposes of receiving State and Federal public benefits.

Effective Date

- Retroactive to August 22, 1996.

Exemption for Certain Indians from Limitation on Eligibility for Supplemental Security Income and Medicaid Benefits (Section 5303)

Provision

- Exceptions are created to the ban on SSI and Medicaid benefits for non-U.S. citizen American Indians: (1) who were born in Canada and have free U.S. border-crossing rights under the Immigration and Nationality Act, or (2) who are members of Federally-recognized American Indian tribes, as defined under the Indian Self-Determination and Education Assistance Act. The SSI and Medicaid exceptions apply to the specified categories of non-U.S. citizen Indian people already in the U.S. and to those entering the U.S. in the future.

Effective Date

- Retroactive to August 22, 1996.

Exemption from Restriction on Supplemental Security Income Program Participation by Certain Recipients Eligible on the Basis of Very Old Applications (Section 5304)

Provision

- SSI benefits are retained for otherwise-eligible individuals receiving benefits for months after July, 1996, if those individuals are eligible on the basis of applications filed before January 1, 1979, if the Social Security Administration lacks clear and convincing evidence that the individuals are not eligible for SSI because of the restrictions on providing SSI to individuals who are not aliens (i.e., where the individuals were born in

towns that no longer exist, or where there is no record of birth available).

Effective Date

o Retroactive to August 22, 1996.

Reinstatement of Eligibility for Medicaid Benefits (Section 5305)

Provision

o Provides a Medicaid exemption to the restrictions on benefits to certain immigrants for individuals who receive SSI benefits. As a result of these amendments to the welfare reform law, aliens who receive SSI will be eligible for Medicaid to the same extent as other SSI recipients.

Effective Date

o Retroactive to August 22, 1996.

Treatment of Certain Amerasian Immigrants as Refugees (Section 5306)

Provision

o Certain Amerasian immigrants are redefined as refugees for purposes of receiving Federal public benefits. As a result, this group is excepted from the 5-year ban on benefits enacted in welfare reform and are also provided with a time-limited exception which would require States to provide them with Medicaid if they are otherwise eligible.

Effective Date

o Retroactive to August 22, 1996.

Chapter 4--Restricting Welfare and Public Benefits for Aliens

Verification of Eligibility for State and Local Public Benefits (Section 5572)

Provision

o Authorizes States to require verification of eligibility for State and local public benefits.

Effective Date

o Retroactive to August 22, 1996.

MISCELLANEOUS PROVISIONS AFFECTING MEDICAID

Coordinated Acute and Long-Term Care Benefits Under a Medicare+Choice Plan (Section 4001) (New Medicare provision, Section 1859(d))

Provision

- Nothing in the newly enacted Medicare+Choice program will prevent a State from coordinating the full range of acute and long-term care benefits under Medicaid and Medicare for persons eligible for both programs.

Effective Date

- Upon implementation of Medicare+Choice. (Interim final regulations to be published by June 1, 1998.)

Coverage of Services in Religious Non-Medical Health Care Institutions Under the Medicare and Medicaid Programs (Section 4454)

Provision

- Various Medicare and Medicaid requirements providing for State agency establishment and enforcement of standards and inspections have long allowed specific exceptions for Christian Science sanitoria. A recent Federal court case struck down these exceptions because they were limited to Christian Scientist sanitoria only, a violation of the Constitution.

  The new law deletes statutory references to Christian Scientist sanitoria and replaces them with the term, "religious nonmedical health care institutions." The provision includes detailed eligibility criteria for facilities to protect the health and safety of patients, and limits the total amount of expenditures that can be paid to the religious nonmedical health care institutions.

Effective Date

- Applies to items and services furnished on or after the date of enactment.
  - The Secretary of HHS must issue implementing regulations no later than July 1, 1998 (which may be issued as interim final).

Limitation on Pension for Certain Recipients of Medicaid-Covered Nursing Home Care (Section 8015)

Provision

- Extends the previous sunset date from September 30, 1998 to September 30, 2002, for the reduction of VA pensions to $90 for veterans who are receiving Medicaid assistance in paying for nursing home care.

Effective Date

- Not specified.